

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Items 18-67 Film 389
5-24-67

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07270

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN lb 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 400 Mitchell Ave.				d. STREET ADDRESS 400 Mitchell Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BETTY Middle VIRGINIA Last ANDERSON				4. DATE OF DEATH Month May Day 7 Year 1967			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 24, 1921		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk			10b. KIND OF BUSINESS OR INDUSTRY goodwill inds.		11. BIRTHPLACE (State or foreign country) Rada, W. Va.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Hugh R. Anderson				14. MOTHER'S MAIDEN NAME Olive Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 219-12-0705		17. INFORMANT Hugh R. Anderson, Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis, severe DUE TO (b) General arteriosclerosis & DUE TO (c) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enterocolitis & benign nephrosclerosis							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto, III			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 217 W. Wash. St. 5-8-67	
EXAMINER'S NAME (Type) Edward W. Ditto, III			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5-10-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07292

07271

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1121 Fairview Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Thomas</u> Last <u>Arcidiacono</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1952</u>		9. AGE (In years lost birthday) yrs. <u>14</u>	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Arcidiacono</u>				14. MOTHER'S MAIDEN NAME <u>Mary Julia Fitzgerald</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-54-8037</u>		17. INFORMANT <u>Thomas Arcidiacono 1121 Fairview Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hematoma</u> 9104 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by baseball</u>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>5/18/67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ball Park</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		EXAMINER'S NAME (Type) <u>Howard N. Weeks, M. D.</u>		22. DATE SIGNED <u>5/29/67</u>		23. ADDRESS (State, City, town, or county) <u>580 Northern Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25. REC'D BY REGISTRAR <u>JUN 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1958

1958

1958

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07293

07272

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Weverton		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Weverton		d. STREET ADDRESS RFD#2, Knoxville, Md. 21758	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Residence				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HAYWARD Middle LESLIE Last BAER		4. DATE OF DEATH Month May Day 28, Year 19 67		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1917		9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Brunswick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ollie Osborne Baer				14. MOTHER'S MAIDEN NAME Edna Mae Barnhart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 579-03-5031		17. INFORMANT Mrs. Elizabeth L. Baer		18. RFD#2, Knoxville, Maryland 21758	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno-Carcinoma - rt. Lung</u> 163X DUE TO (b) <u>Local & generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 18 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from May 6, 1967, to May 28, 1967, that I (we) last saw the deceased alive on May 28, 1967, and that death occurred at 6:15 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-1-67	
22c. PHYSICIAN'S NAME (Type) C.E. Pruitt, M.D.		22d. ADDRESS Brunswick, Maryland 21716					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/67		23c. NAME OF CEMETERY OR CREMATORY Brownsville Heights		23d. LOCATION (City, town or county) (State) Brownsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS Harpers Ferry, W.Va.		25a. RECEIVED BY REGISTRAR JUN 6 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

000000

000000

CENTRAL BANK OF AMERICA

WEIGHT

110

WEIGHT

WEIGHT, KNOWN

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

WEIGHT

110

WEIGHT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07294

07273

1. PLACE OF DEATH a. COUNTY WASHINGTON COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN Rt #2				c. LENGTH OF STAY IN 1b 21.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS KING ST			
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last BRANZHOFF # 1				4. DATE OF DEATH Month 5 Day 21 Year 1967			
5. SEX FEMALE W		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/20/67	
9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) U-S-A	
12. CITIZEN OF WHAT COUNTRY U-S-A							
13. FATHER'S NAME CHARLES KELLER				14. MOTHER'S MAIDEN NAME NANCY DIAN BOYD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYALINE Membrane disease DUE TO (c) Immaturity							INTERVAL BETWEEN ONSET AND DEATH 24 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prematurity							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/20/1967 to 5/21/1967 , that (I) (we) last saw the deceased alive on 5/21/1967 , and that death occurred at 11:55 PM , from causes and on the date stated above.							
22a. SIGNATURE Ronald Keyser				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/22/67	
22c. PHYSICIAN'S NAME (Type) RONALD E KEYSER				22d. ADDRESS 101 King Street HAGERSTOWN			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF MAY 23, 1967		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON COUNTY HOSPITAL		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, MARYLAND	
24. FUNERAL DIRECTOR John Schaffer, Adm. Wash Co Hosp				25a. REC'D BY REGISTRAR MAY 26 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

WASHINGTON COUNTY
RECEIVED
JAN 21 1967

WASHINGTON COUNTY
JAN 21 1967
RECEIVED

WASHINGTON COUNTY
JAN 21 1967
RECEIVED

WASHINGTON COUNTY
JAN 21 1967
RECEIVED

WASHINGTON COUNTY
JAN 21 1967
RECEIVED

WASHINGTON COUNTY
JAN 21 1967
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07295

CERTIFICATE OF DEATH

07274

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON County Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL BANZHOFF</u>		4. DATE OF DEATH <u>5</u> <u>21</u> <u>19</u> <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/67</u>
9. AGE (In years last birthday) yrs. <u>4</u> <u>20</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>CHARLES KELLER BANZHOFF</u>		14. MOTHER'S MAIDEN NAME <u>NANCY DIAN BOYD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Address</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Atelectasis</u> DUE TO (b) <u>Immaturity of lungs</u> DUE TO (c) <u>Immaturity of lungs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Immaturity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>67</u> , to <u>5/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> , 19 <u>67</u> and that death occurred at <u>3:20 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Ronald E. Keyser</u> M.D.		22b. DATE SIGNED <u>5/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD E. KEYSER</u>		22d. ADDRESS <u>101 KING ST HAGERSTOWN, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>MAY 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON COUNTY HOSPITAL</u>	23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN, MARYLAND</u>
24. FUNERAL DIRECTOR <u>John Schoffer, Adm. Wash Co. Hosp</u>		25a. REC'D BY REGISTRAR <u>MAY 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

7-227575

Ronald E. Keyser 101 King St Hagerstown, MD
 2/21 2/21 2/21 2/21 2/21 2/21 2/21 2/21 2/21 2/21
 2/21 2/21 2/21 2/21 2/21 2/21 2/21 2/21 2/21 2/21

Primarily

Immunity of family
 Primarily affected

NO NO
 CHARLES KETER BAUSHAFF
 NANCY ANN GOLD

Infant
 Female W
 2/20/61
 Bauschhoff

Washington County 1969
 Hagerstown 5-16
 Rt 5 Hagerstown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07296					07275					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Washington</u> MARYLAND					a. STATE <u>Md</u> b. COUNTY <u>—</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
<u>Williamsport</u>				<u>Baltimore - 21214</u> 30.4						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Homewood Church Home Inc</u>					<u>5609 Birchwood Ave.</u>					
3. NAME OF DECEASED					4. DATE OF DEATH					
(Type or print) First Middle Last					Month Day Year					
<u>Louise Matilda Benson</u>					<u>May 20 1967</u>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		
<u>F</u>		<u>W</u>				<u>Oct 24, 1876</u>		<u>90</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
<u>Milliner</u>			<u>Milliner</u>			<u>Baltimore</u>			<u>USA</u>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
<u>Thomas J. Benson</u>					<u>Matilda Whiting</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
<u>no</u>			<u>219-05-6212A</u>		<u>Markell Wagner</u>			<u>2750 Va Ave Williamsport, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Styptostatic Pneumonia</u>								<u>48 hours</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Styptensive CV. Disease</u>								<u>17 years</u>		
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15</u> , 1965, to <u>5-20</u> , 1967, that (I) (we) last saw the deceased alive on <u>5-18</u> , 1967, and that death occurred at <u>9:15 A.M.</u> , from causes and on the date stated above.										
22a. SIGNATURE <u>Robert P. Conrad</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>5-20-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad, MD</u>					22d. ADDRESS <u>137 W. Washington Stagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
<u>Burial</u>			<u>May. 23. 1967</u>		<u>Baltimore Cemetery</u>			<u>Baltimore Md.</u>		
24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u> ADDRESS <u>Baltimore Md.</u>					25a. RECEIVED BY REGISTRAR <u>MAY 22 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

STATE OF NEW YORK

1990

IN SENATE
January 1, 1990

REPORT OF THE
COMMISSIONER OF TAXATION
AND FINANCE

FOR THE YEAR
ENDING DECEMBER 31, 1989

ALBANY, NEW YORK
JANUARY 1, 1990

PRINTED BY THE
STATE OF NEW YORK

ALBANY, NEW YORK
JANUARY 1, 1990

PRINTED BY THE
STATE OF NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07297

07276

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle 75-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor</u>		d. STREET ADDRESS <u>237 E. Balto. St.</u>	
3. NAME OF DECEASED (Type or print) <u>ANNIE F. Binkley</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/1880</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Newspaper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Antrim Twp., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. W. Leshner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Shank</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Lynn Bear</u>		Address <u>PO Box Greencastle, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombophlebitis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease with congestive failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/29/67</u> , 19 <u>67</u> , to <u>5/29/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/29/67</u> , 19 <u>67</u> , and that death occurred at <u>4:20 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>D. R. Hess, Jr.</u>		22b. DATE SIGNED <u>5/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. R. Hess, Jr.</u>		22d. ADDRESS <u>SHADY GROVE, PA.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE THEREOF <u>6/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Greencastle, Pa.</u>
24. FUNERAL DIRECTOR <u>R. E. Minnich - Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00000

CERTIFICATE OF DEATH

Attest
I hereby certify that
the within and foregoing
is a true and correct
copy of the original
as the same appears
from the records
of the office of the
Registrar of the
County of [blank]
State of [blank]

Witness my hand and
the seal of the office
this [blank] day of [blank]
A.D. 19[blank]

Notary Public for the State of [blank]
My commission expires on the [blank] day of [blank]
A.D. 19[blank]

Subscribed and sworn to before me this [blank] day of [blank]
A.D. 19[blank]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07298		07277	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN lb <u>D.O.A.</u>		d. STREET ADDRESS <u>2377 Penna Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>SUTTON</u> Last <u>BOWEN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 7 1909</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Verona Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua Sutton</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Daggy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr Archie L. Hinkle</u>		Address <u>2377 Penna Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>5 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3 May 1967</u> , and that death occurred at <u>9 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Wilson</u>		22b. DATE SIGNED <u>11/767</u>	
22c. PHYSICIAN'S NAME (Type) <u>John D. Wilson</u>		22d. ADDRESS <u>580 Northern Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Verona E.U.B. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Augusta Co Va.</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc</u>		25. REC'D BY REGISTRAR <u>MAY 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

STATE OF TEXAS

1933

County of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Va. b. COUNTY Doddridge	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Salem	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS RFD 2	
3. NAME OF DECEASED (Type or print) First KARL Middle NMN Last CARPENTER		4. DATE OF DEATH Month May Day 11 , Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-75
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY oil Co.	
11c. BIRTHPLACE (County & State, or foreign country) Bridgeport, W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William A. Carpenter		14. MOTHER'S MAIDEN NAME Ida Stout	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT W. G. Carpenter, Jefferson, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) benign prostatic hyperplasia - terminal uremia		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-8 , 1967, to 5-10 , 1967, that (I) (we) last saw the deceased alive on 5-10 , 1967, and that death occurred at 1:00 A.M., from causes and on the date stated above.			
22a. SIGNATURE Joseph C. Crisp		22b. DATE SIGNED 5-11-67	
22c. PHYSICIAN'S NAME (Type) JOS C. CRISP MD		22d. ADDRESS 580 northern ave. Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5014-67	
23c. NAME OF CEMETERY OR CREMATORY Salem I.O.O.F. Cem		23d. LOCATION (City or Town) (County) (State) Salem, W. Va.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAY 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

05200

CERTIFICATE OF DEATH

Washington

CARPENTER

KARL

Washington, D.C.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07300

07279

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b LIFE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 331 S. MULBERRY ST.				d. STREET ADDRESS 331 S. MULBERRY ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSTIE Middle VIRGINIA Last CARTER				4. DATE OF DEATH Month MAY Day 15 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1928		9. AGE (In years last birthday) yrs. 38	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES WM. ALLEN SR.				14. MOTHER'S MAIDEN NAME MABEL SECORD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. THOMAS E. CARTER MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty metamorphosis liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe - with suspected hypoglycemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic valvulopathy & Stenosis						INTERVAL BETWEEN ONSET AND DEATH Unknown Minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.				22. DATE SIGNED 5-16-67			
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.				DEPUTY MEDICAL EXAMINER 217 W. Wash. St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/18/67		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.	
24. FUNERAL DIRECTOR W.J. Normant, Hagerstown, Md.				25a. REC'D BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0730

WASHINGTON

WASHINGTON

WASHINGTON

331 S. BUREAU ST.

331 S. BUREAU ST.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 6389 5/26/67 kk

07301

CERTIFICATE OF DEATH

07280

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 60 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 940B Lanvale St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Luther Comer, Sr.				4. DATE OF DEATH Month Day Year May 18 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1889		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) conductor		10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (County & State, or foreign country) Luray, Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David L. Comer				14. MOTHER'S MAIDEN NAME Emma J. Dawson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-10-8232		17. INFORMANT Address Mrs Julia Comer, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus (Acquired) 344.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia						INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 1967 , to May 18, 1967 , that (I) (we) last saw the deceased alive on May 18, 1967 , and that death occurred at 2 P M, from causes and on the date stated above.							
22a. SIGNATURE Dr. Charles Spencer M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Charles Spencer				22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 5-20-1967	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE g Charles Judge	

MEDICAL CERTIFICATION

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07302

CERTIFICATE OF DEATH

07281

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 2 wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				d. STREET ADDRESS 346 Ringgold St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle E. Last Cook				4. DATE OF DEATH Month May Day 11 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 31, 1896		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Landis Machine Co.		11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter S. Cook				14. MOTHER'S MAIDEN NAME Charlotte Kuhn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 173-03-08341		17. INFORMANT Mrs. Paul E. Cook		Address Waynesboro, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Right Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholism, Emphysema, Dec. 4/8/1964						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 22, 1966 , to May 11, 1967 , that (I) (we) last saw the deceased alive on May 10, 1967 , and that death occurred at 5:44 A.M. from causes on and on the date stated above.							
22a. SIGNATURE E. L. Laddizah				22b. DATE SIGNED 5-11-1967		22c. PHYSICIAN'S NAME (Type) E. L. Laddizah	
22d. ADDRESS 600 N. Roberts Hagerstown, Md.		22e. ADDRESS 600 N. Roberts Hagerstown, Md.		22f. ADDRESS 600 N. Roberts Hagerstown, Md.		22g. ADDRESS 600 N. Roberts Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/14/1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Greencastle, Franklin, Penna.	
24. FUNERAL DIRECTOR Walter G. Jones				25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	

STATEMENT OF DEATH

03304

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Manner of death: [illegible]
10. Signature of physician: [illegible]
11. Signature of coroner: [illegible]
12. Signature of registrar: [illegible]
13. Date of filing: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07303

CERTIFICATE OF DEATH

07282

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 40 YEARS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 474 NORTH POTOMAC STREET,				d. STREET ADDRESS 474 NORTH POTOMAC STREET,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE N. CRAMER				4. DATE OF DEATH Month Day Year MAY 22, 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 11, 1909		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES K. NOEL, SR.				14. MOTHER'S MAIDEN NAME LOLA PERKINS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-26-7240		17. INFORMANT MR. HARRY P. CRAMER, 474 NORTH POTOMAC ST. HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vasc. Disease DUE TO (c) Obesity						INTERVAL BETWEEN ONSET AND DEATH 1 hr. 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from Jan. 10, 1955 to May 22, 1967 , that (I) know saw the deceased alive on May 22, 1967 , and that death occurred at 6:30 A.M. from causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. LLOYD A. HOFFMAN, M.D.				22d. ADDRESS 214 NORTH POTOMAC ST. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/24/67		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY,		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR MAY 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

100

100

COMMISSIONER OF DEATH
AND
VITAL STATISTICS

REPORT
FOR THE YEAR 1902

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.
1903.

DEATHS		BIRTHS		MARRIAGES		DIVORCES	
MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
1,234	1,567	2,345	2,678	3,456	3,789	4,567	4,890
1,345	1,678	2,456	2,789	3,567	3,890	4,678	5,012
1,456	1,789	2,567	2,890	3,678	4,012	4,789	5,123
1,567	1,890	2,678	3,012	3,789	4,123	4,890	5,234
1,678	2,012	2,789	3,123	3,890	4,234	5,012	5,345
1,789	2,123	2,890	3,234	4,012	4,345	5,123	5,456
1,890	2,234	3,012	3,345	4,123	4,456	5,234	5,567
1,901	2,345	3,123	3,456	4,234	4,567	5,345	5,678
2,012	2,456	3,234	3,567	4,345	4,678	5,456	5,789
2,123	2,567	3,345	3,678	4,456	4,789	5,567	5,890
2,234	2,678	3,456	3,789	4,567	4,890	5,678	5,901
2,345	2,789	3,567	3,890	4,678	5,012	5,789	6,012
2,456	2,890	3,678	4,012	4,789	5,123	5,890	6,123
2,567	3,012	3,789	4,123	4,890	5,234	5,901	6,234
2,678	3,123	3,890	4,234	5,012	5,345	6,012	6,345
2,789	3,234	4,012	4,345	5,123	5,456	6,123	6,456
2,890	3,345	4,123	4,456	5,234	5,567	6,234	6,567
2,901	3,456	4,234	4,567	5,345	5,678	6,345	6,678
3,012	3,567	4,345	4,678	5,456	5,789	6,456	6,789
3,123	3,678	4,456	4,789	5,567	5,890	6,567	6,890
3,234	3,789	4,567	4,890	5,678	5,901	6,678	6,901
3,345	3,890	4,678	5,012	5,789	6,012	6,789	7,012
3,456	4,012	4,789	5,123	5,890	6,123	6,890	7,123
3,567	4,123	4,890	5,234	5,901	6,234	6,901	7,234
3,678	4,234	5,012	5,345	6,012	6,345	7,012	7,345
3,789	4,345	5,123	5,456	6,123	6,456	7,123	7,456
3,890	4,456	5,234	5,567	6,234	6,567	7,234	7,567
3,901	4,567	5,345	5,678	6,345	6,678	7,345	7,678
4,012	4,678	5,456	5,789	6,456	6,789	7,456	7,789
4,123	4,789	5,567	5,890	6,567	6,890	7,567	7,890
4,234	4,890	5,678	6,012	6,678	6,901	7,678	7,901
4,345	5,012	5,789	6,123	6,789	7,012	7,789	8,012
4,456	5,123	5,890	6,234	6,890	7,123	7,890	8,123
4,567	5,234	6,012	6,345	6,901	7,234	7,901	8,234
4,678	5,345	6,123	6,456	7,012	7,345	8,012	8,345
4,789	5,456	6,234	6,567	7,123	7,456	8,123	8,456
4,890	5,567	6,345	6,678	7,234	7,567	8,234	8,567
4,901	5,678	6,456	6,789	7,345	7,678	8,345	8,678
5,012	5,789	6,567	6,890	7,456	7,789	8,456	8,789
5,123	5,890	6,678	7,012	7,567	7,890	8,567	8,890
5,234	6,012	6,789	7,123	7,678	7,901	8,678	8,901
5,345	6,123	6,890	7,234	7,789	8,012	8,789	9,012
5,456	6,234	7,012	7,345	7,890	8,123	8,890	9,123
5,567	6,345	7,123	7,456	7,901	8,234	8,901	9,234
5,678	6,456	7,234	7,567	8,012	8,345	9,012	9,345
5,789	6,567	7,345	7,678	8,123	8,456	9,123	9,456
5,890	6,678	7,456	7,789	8,234	8,567	9,234	9,567
5,901	6,789	7,567	7,890	8,345	8,678	9,345	9,678
6,012	6,890	7,678	8,012	8,456	8,789	9,456	9,789
6,123	7,012	7,789	8,123	8,567	8,890	9,567	9,890
6,234	7,123	7,890	8,234	8,678	8,901	9,678	9,901
6,345	7,234	8,012	8,345	8,789	9,012	9,789	10,012
6,456	7,345	8,123	8,456	8,890	9,123	9,890	10,123
6,567	7,456	8,234	8,567	8,901	9,234	9,901	10,234
6,678	7,567	8,345	8,678	9,012	9,345	10,012	10,345
6,789	7,678	8,456	8,789	9,123	9,456	10,123	10,456
6,890	7,789	8,567	8,890	9,234	9,567	10,234	10,567
6,901	7,890	8,678	9,012	9,345	9,678	10,345	10,678
7,012	8,012	8,789	9,123	9,456	9,789	10,456	10,789
7,123	8,123	8,890	9,234	9,567	9,890	10,567	10,890
7,234	8,234	9,012	9,345	9,678	9,901	10,678	10,901
7,345	8,345	9,123	9,456	9,789	10,012	10,789	11,012
7,456	8,456	9,234	9,567	9,890	10,123	10,890	11,123
7,567	8,567	9,345	9,678	9,901	10,234	10,901	11,234
7,678	8,678	9,456	9,789	10,012	10,345	11,012	11,345
7,789	8,789	9,567	9,890	10,123	10,456	11,123	11,456
7,890	8,890	9,678	10,012	10,234	10,567	11,234	11,567
7,901	8,901	9,789	10,123	10,345	10,678	11,345	11,678
8,012	9,012	9,890	10,234	10,456	10,789	11,456	11,789
8,123	9,123	10,012	10,345	10,567	10,890	11,567	11,890
8,234	9,234	10,123	10,456	10,678	10,901	11,678	11,901
8,345	9,345	10,234	10,567	10,789	11,012	11,789	12,012
8,456	9,456	10,345	10,678	10,890	11,123	11,890	12,123
8,567	9,567	10,456	10,789	10,901	11,234	11,901	12,234
8,678	9,678	10,567	10,890	11,012	11,345	12,012	12,345
8,789	9,789	10,678	10,901	11,123	11,456	12,123	12,456
8,890	9,890	10,789	11,012	11,234	11,567	12,234	12,567
8,901	9,901	10,890	11,123	11,345	11,678	12,345	12,678
9,012	10,012	10,901	11,234	11,456	11,789	12,456	12,789
9,123	10,123	11,012	11,345	11,567	11,890	12,567	12,890
9,234	10,234	11,123	11,456	11,678	11,901	12,678	12,901
9,345	10,345	11,234	11,567	11,789	12,012	12,789	13,012
9,456	10,456	11,345	11,678	11,890	12,123	12,890	13,123
9,567	10,567	11,456	11,789	11,901	12,234	12,901	13,234
9,678	10,678	11,567	11,890	12,012	12,345	13,012	13,345
9,789	10,789	11,678	11,901	12,123	12,456	13,123	13,456
9,890	10,890	11,789	12,012	12,234	12,567	13,234	13,567
9,901	10,901	11,890	12,123	12,345	12,678	13,345	13,678
10,012	11,012	11,901	12,234	12,456	12,789	13,456	13,789
10,123	11,123	12,012	12,345	12,567	12,890	13,567	13,890
10,234	11,234	12,123	12,456	12,678	12,901	13,678	13,901
10,345	11,345	12,234	12,567	12,789	13,012	13,789	14,012
10,456	11,456	12,345	12,678	12,890	13,123	13,890	14,123
10,567	11,567	12,456	12,789	12,901	13,234	13,901	14,234
10,678	11,678	12,567	12,890	13,012	13,345	14,012	14,345
10,789	11,789	12,678	12,901	13,123	13,456	14,123	14,456
10,890	11,890	12,789	13,012	13,234	13,567	14,234	14,567
10,901	11,901	12,890	13,123	13,345	13,678	14,345	14,678
11,012	12,012	12,901	13,234	13,456	13,789	14,456	14,789
11,123	12,123	13,012	13,345	13,567	13,890	14,567	14,890
11,234	12,234	13,123	13,456	13,678	13,901	14,678	14,901
11,345	12,345	13,234	13,567	13,789	14,012	14,789	15,012
11,456	12,456	13,345	13,678	13,890	14,123	14,890	15,123
11,567	12,567	13,456	13,789	13,901	14,234	14,901	15,234
11,678	12,678	13,567	13,890	14,012	14,345	15,012	15,345
11,789	12,789	13,678	13,901	14,123	14,456	15,123	15,456
11,890	12,890	13,789	14,012	14,234	14,567	15,234	15,567
11,901	12,901	13,890	14,123	14,345	14,678	15,345	15,678
12,012	13,012	13,901	14,234	14,456	14,789	15,456	15,789
12,123	13,123	14,012	14,345	14,567	14,890	15,567	15,890
12,234	13,234	14,123	14,456	14,678	14,901	15,678	15,901
12,345	13,345	14,234	14,567	14,789	15,012	15,789	16,012
12,456	13,456	14,345	14,678	14,890	15,123	15,890	16,123
12,567	13,567	14,456	14,789	14,901	15,234	15,901	16,234
12,678	13,678	14,567	14,890	15,012	15,345	16,012	16,345
12,789	13,789	14,678	14,901	15,123	15,456	16,123	16,456
12,890	13,890	14,789	15,012	15,234	15,567	16,234	16,567
12,901	13,901	14,890	15,123	15,345	15,678	16,345	16,678
13,012	14,012	14,901	15,234	15,456	15,789	16,456	16,789
13,123	14,123	15,012	15,345	15,567	15,890	16,567	16,890
13,234	14,234	15,123	15,456	15,678	15,901	16,678	16,901
13,345	14,345	15,234	15,567	15,789	16,012	16,789	17,012
13,456	14,456	15,345	15,678	15,890	16,123	16,890	17,123
13,567	14,567	15,456	15,789	15,901	16,234	16,901	17,234
13,678	14,678	15,567	15,890	16,012	16,345	17,012	17,345
13,789	14,789	15,678	15,901	16,123	16,		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07304

CERTIFICATE OF DEATH

07283

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Conv. Hosp.</u>				d. STREET ADDRESS <u>R.D.1</u>			
3. NAME OF DECEASED (Type or print) <u>Albert Russell Creager</u>				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/5/1892</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Shop Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mercersburg, Pa., R.1</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David W. Creager</u>				14. MOTHER'S MAIDEN NAME <u>Susan L. Lightner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>200-24-1633</u>		17. INFORMANT Address <u>Pa., R. #1</u> <u>Mrs. Albert R. Creager, St. Thomas.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease With</u> <u>4200</u> DUE TO <u>Decompensation.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Several</u> years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 14, 1967</u> , to <u>May 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 8, 1967</u> , and that death occurred at <u>6:30 M.</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>Edward W. Ditto, III</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>				22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Mercersburg, Pa.</u>	
24. FUNERAL DIRECTOR <u>Chas. L. Linger</u>				ADDRESS <u>Mercersburg, Pa.</u>		25a. REC'D BY REGISTRAR <u>MAY 17 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03304

TO THE CHIEF OF BUREAU

1941

1. The first part of the report

2. The second part of the report

3. The third part of the report

4. The fourth part of the report

5. The fifth part of the report

6. The sixth part of the report

7. The seventh part of the report

8. The eighth part of the report

9. The ninth part of the report

10. The tenth part of the report

11. The eleventh part of the report

12. The twelfth part of the report

13. The thirteenth part of the report

14. The fourteenth part of the report

15. The fifteenth part of the report

16. The sixteenth part of the report

17. The seventeenth part of the report

18. The eighteenth part of the report

19. The nineteenth part of the report

20. The twentieth part of the report

21. The twenty-first part of the report

22. The twenty-second part of the report

23. The twenty-third part of the report

24. The twenty-fourth part of the report

25. The twenty-fifth part of the report

26. The twenty-sixth part of the report

27. The twenty-seventh part of the report

28. The twenty-eighth part of the report

29. The twenty-ninth part of the report

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07305

CERTIFICATE OF DEATH

07284

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN LIFE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 119 E. LEE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last CRIDER		4. DATE OF DEATH Month MAY Day 15 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/1900 9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY CLEANER		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING	11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM L. CRIDER		14. MOTHER'S MAIDEN NAME NELLIE GRACE BAKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-4885	17. INFORMANT Address MRS. MARGARET L. CRIDER MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X METASTATIC CARCINOMA DUE TO (b) ADENOCARCINOMA OF RECTUM DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2+ yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UREMIA - DEGENERATIVE LEUCODIOSIS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8 FEB. 1965 to 15 MAY 1967 , that (I) (we) last saw the deceased alive on 15 MAY 1967 , and that death occurred at 12 M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 16 MAY 1967	
22c. PHYSICIAN'S NAME (Type) W. N. FENDER		22d. ADDRESS 218 N. Potomac St., Hagerstown, Md.	
23a. BURIAL CREMATION, REINTERMENT BURIAL	23b. DATE THEREOF 5/17/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAY 19 1967	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07306

CERTIFICATE OF DEATH

07285

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>		c. LENGTH OF STAY IN 1b <u>Life time</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>55 W. Bethel Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie Beatrice Davis</u>		4. DATE OF DEATH Month Day Year <u>May 28 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 10 1906</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Halfway, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George T. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Watson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Leonard Davis</u>		Address <u>55 W. Bethel St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5/12/67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 2, 1967</u> , to <u>May 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1967</u> , and that death occurred at <u>1:15 p.m.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Donald E. Martin</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>5/29/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Donald E. Martin, M.D.</u>		22d. ADDRESS <u>418 N. Potomac St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 31 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Maryland</u>
24. FUNERAL DIRECTOR <u>John R. Watson Jr. Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0050

3234

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07286

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen May Dennis		4. DATE OF DEATH May 22, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1909
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home duties	
11. BIRTHPLACE (County & State, or foreign country) Clear Spring, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Forsythe		14. MOTHER'S MAIDEN NAME Mollie Snyder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-48-5464	
17. INFORMANT George P. Dennis Rd. 2, Clspg. Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Mitral Stenosis With Left Heart Failure. DUE TO (c) Recent		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-8 , 19 67 , to 5-22 , 19 67 , that (I) (we) last saw the deceased alive on 5-22 , 19 67 , and that death occurred at 2 P. M, from causes and on the date stated above.			
22a. SIGNATURE Dr. E. W. Ditto, Jr.		22b. DATE SIGNED 5-23-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS 215 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d. LOCATION (City or Town) (County) (State) Clear Spring, Md.	
24. FUNERAL DIRECTOR Margaret Rowland		25a. REC'D BY REGISTRAR MAY 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07307

London

Secretary

In a

Director of

London

London

May

London

London

London

House

London

London

London

London

London



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07308

CERTIFICATE OF DEATH

07289

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 25 years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 455 W. Washington St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cleora Middle Dorethea Last Easterday		4. DATE OF DEATH Month May Day 23 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 20, 1899
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Mt. Airy, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John W. McClelland		14. MOTHER'S MAIDEN NAME Agnes V. Barnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Leroy Easterday, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) athero-sclerosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRINCIPAL DISEASE CONDITION GIVEN IN PART I (a) Libertine Mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23, 1967 to May 23, 1967 and that death occurred at 1045 AM from causes and on the date stated above.			
22a. SIGNATURE J. H. Beachley		22b. DATE SIGNED 5/24/67	
22c. PHYSICIAN'S NAME (Type) J. H. Beachley		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5-26-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAY 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

0833

0833

UNITED STATES OF AMERICA

Washington

Department of State

Office of the Secretary

Washington, D.C.

January 1, 1944

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07303

CERTIFICATE OF DEATH

07287

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Maugansville Md.</u>				c. LENGTH OF STAY IN <u>1b</u> years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maugansville Mennonite Home</u>				d. STREET ADDRESS <u>Greene Twp.</u>			
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>L.</u> Last <u>EBY</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>23</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1870</u>		9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co.-Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry Ebersole</u>				14. MOTHER'S MAIDEN NAME <u>Martha Lehman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Ira.L. Eby</u> Address <u>R.R.#1, Chambersburg Pa.17201</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>		
21. I certify that (1) <u>(my hospital)</u> attended the deceased from <u>January</u> , 19 <u>60</u> , to <u>May 23</u> , 19 <u>67</u> , that (1) <u>X</u> saw the deceased alive on <u>February</u> 19 <u>67</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>E. W. DITTO, JR.</u>				22b. DATE SIGNED <u>MAY 26, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>E. W. DITTO, JR. M.D.</u>	
22d. ADDRESS <u>215 W. WASHINGTON ST. HAGERSTOWN, MD.</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/27/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chambersburg Mennonite Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Chambersburg-Franklin-Penna.</u>		
24. FUNERAL DIRECTOR <u>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</u>				25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Rouzer</u>	

03302

UNIT 11 OF DEATH

03302

Franklin

Anna

Franklin - Anna

Anna

Franklin - Anna

Franklin - Anna

Anna

03302

Franklin - Anna

Franklin - Anna

Anna

Franklin - Anna

Franklin - Anna

Franklin - Anna

Anna

Franklin - Anna

Franklin - Anna

Anna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please to have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07310

CERTIFICATE OF DEATH

07288

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro Rfd. 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fahrney- Keedy Memorial Home		d. STREET ADDRESS 7 CEDARWOOD RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frances G. Fleagle		4. DATE OF DEATH Month Day Year May 12, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1884
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME NEWTON GUNTHER		14. MOTHER'S MAIDEN NAME SUSAN TAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ROBERT G. FLEAGLE		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 thrombotic cardio DUE TO (b) vessel disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 2, 1967 to May 12, 1967 , that (I) (we) last saw the deceased alive on May 12, 1967 , and that death occurred at 7 P.M. from causes and on the date stated above.			
22a. SIGNATURE G. W. He Van		22b. DATE SIGNED May 13, 1967	
22c. PHYSICIAN'S NAME (Type) G. W. He Van		22d. ADDRESS Boonsboro, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/16/67	23c. NAME OF CEMETERY OR CREMATORY LORRAINE	23d. LOCATION (City or Town) (County) (State) BALTO. CO. MD
24. FUNERAL DIRECTOR E. S. MACNABB		25a. REC'D BY REGISTRAR MAY 17 1967	
ADDRESS 301 FREDERICK RD		25b. REGISTRAR'S SIGNATURE Charles Judge	

10000

10000

[Faint, illegible handwritten text covering the majority of the page]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07290

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland		c. LENGTH OF STAY IN 1b 65yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 237 Suter Ave.		d. STREET ADDRESS 237 Suter Ave.	
3. NAME OF DECEASED (Type or print) Joseph Gabriel French		4. DATE OF DEATH Month May Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1 1898
9. AGE (In years lost birthday) yrs. 69		IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Front Royal Va.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack French		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War 1	
17. INFORMANT Nettie French		Address 237 Suter Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Artery Disease DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 8 , 19 63 , to MAY 5 , 19 67 , that (I) (we) last saw the deceased alive on MAY 5 , 19 67 , and that death occurred at 5:42 P.M. from causes and on the date stated above.			
22a. SIGNATURE W. N. FENDER		22b. DATE SIGNED 6 MAY 1967	
22c. PHYSICIAN'S NAME (Type) W. N. FENDER		22d. ADDRESS 218 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 11 1967	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City or Town) (County) (State) Gettysburg, Pa
24. FUNERAL DIRECTOR John R Watson Jr Hagerstown Md.		25a. REC'D BY REGISTRAR MAY 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1550

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07314

CERTIFICATE OF DEATH

07291

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
c. LENGTH OF STAY IN 1b 50 YEARS		d. STREET ADDRESS 412 WEST WASHINGTON ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOGAN Middle ANTHONY Last GALLAGHER, SR.		4. DATE OF DEATH Month MAY Day 30 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4, 1891
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAVERN OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY OWN TAVERN	11. BIRTHPLACE (County & State, or foreign country) ELBERTON, PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DAN S. GALLAGHER	
14. MOTHER'S MAIDEN NAME ANNIE R. (LAST NAME UNKNOWN)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 705-10-5341		17. INFORMANT Address W. WASHINGTON ST. WILLIAM TERRY GALLAGHER, HAGERSTOWN, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding Esophageal varices (8 hrs.) 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the Liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (my hospital) attended the deceased from 5/28, 1967 , to 5/29, 1967 , that (I) (we) last saw the deceased alive on 5/29, 1967 , and that death occurred at 7:30 AM from causes and on the date stated above. 22a. SIGNATURE Arturo Riego M.D. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED MAY 31, 1967 22c. PHYSICIAN'S NAME (Type) ARTURO RIEGO M.D. 22d. ADDRESS 159 W. WASHINGTON ST. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/2/67	
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MARYLAND.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR JUN 2 1967 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

315

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07312

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07292

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE West Virginia b. COUNTY Jefferson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 12 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS RFD#2, Harpers Ferry	
3. NAME OF DECEASED (Type or print) Edith First Geneva Middle Garrett Last Garrett		4. DATE OF DEATH Month 5 Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1912
9. AGE (In years lost birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Line		10b. KIND OF BUSINESS OR INDUSTRY Bookbinder	
11. BIRTHPLACE (State or foreign country) Chestnut Hill, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Humphrey Lee Wilt		14. MOTHER'S MAIDEN NAME Ida Eugene Pearl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. 235-32-0902	
17. INFORMANT Mrs. Dolores Jenkins Address RFD#2, Harpers Ferry, West Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 193.0 IMMEDIATE CAUSE (a) Brown tumor - Rstrectomy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. gd 3 (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 3-8-1902	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III M.D. EXAMINER'S NAME (Type) 217 W. WASHINGTON ST. HAG., MD.		22. DATE SIGNED 5-8-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/10/67	
23c. NAME OF CEMETERY OR CREMATORY Chestnut Hill Cemetery, Chestnut Hill, W.Va.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Donald Ecker		25. RECEIVED BY REGISTRAR MAY 10 1967 DATE	

31813

West Hill

West Hill, West Hill

West Hill

West Hill, West Hill

West Hill, West Hill

West Hill, West Hill

West Hill, West Hill

West Hill, West Hill

West Hill, West Hill

EDWARD W. DITTO, III
217 W. WASHINGTON ST. HAG, MD.

West Hill, West Hill
West Hill, West Hill

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07313

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07293

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 66 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MERLE Middle SCOTT Last GIBNEY		4. DATE OF DEATH Month May Day 21 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 24 1900-66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) florist		10b. KIND OF BUSINESS OR INDUSTRY greenhouse	9. AGE (In years last birthday) yrs. 66
11. BIRTHPLACE (State or foreign country) Hagerstown, Md		12. CITIZEN OF WHAT COUNTRY? 21.1	
13. FATHER'S NAME Walter S. Gibney		14. MOTHER'S MAIDEN NAME Elsie Conrad	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-0340A	
17. INFORMANT Frances Gibney, Hagerstown, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1) Brain stem damage DUE TO 2) Cerebral contusions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3) Subarachnoid hemorrhage with basal and occipital skull fracture (c) 9036		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Undetermined-Fell striking head on concrete.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5/20 1967		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Green house
20f. (City or town) Hagerstown Wash. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard N. Weeks EXAMINER'S NAME (Type) Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) Hagerstown, Md.	
22. DATE SIGNED 5/22/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 5-24-1967	23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	23d. LOCATION (City or Town) (County) (State) Williamsport Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, MD		25a. REC'D BY REGISTRAR DATE MAY 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

100-100

100-100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07294

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 15 LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS RT.#6 HAGERSTOWN	
3. NAME OF DECEASED (Type or print) First DALTA Middle RAE Last GRIMM		4. DATE OF DEATH Month MAY Day 24 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 24 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK		10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IRVIN R. GRIMM		14. MOTHER'S MAIDEN NAME LILA V. BEARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MISS CARRIE P. GRIMM		Address RT.#6 HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Atherosclerosis, generalized + DUE TO Astenosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 4-5 hrs 25 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aspiration of gastric Contents.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1963 , to May 24, 1967 , that (I) (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 7:30 P M, from causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III		22b. DATE SIGNED 5-26-67	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D.		22d. ADDRESS 217 W. Washington Street Hagerstown, Maryland	
23a. BURIAL CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 5/27/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W.J. Norman, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAY 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

10070

10317

CHARTER

RECEIVED

THE

ONE

RECEIVED

RECEIVED

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, of this to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07316

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07295

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>2 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>238 So Mulberry St</u>				d. STREET ADDRESS <u>238 So Mulberry St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DONALD LEE HARBAUGH</u>				4. DATE OF DEATH Month Day Year <u>May 10 1967</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>March 19 1911</u> 56 yrs.		9. AGE (In years lost birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>E.J. Pennell Co</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman L. Harbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Bertha M. Ausherman</u> St			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>414-09-7375</u>		17. INFORMANT <u>Mrs Bertha M. Harbaugh</u> Address <u>238 So Mulberry St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis, severe;</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>general atherosclerosis and</u> DUE TO (c) <u>Arterio sclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u> <u>10-15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Chronic Alcoholism ② Rib Fractures</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Edward W. Dittus III</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>217 W. Washington St</u>		Address (Street, city, town, or county) <u>Hagerstown Md</u>		22. DATE SIGNED <u>5/11/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>	
24. FUNERAL DIRECTOR <u>Hagerstown Md.</u> <u>Andrew K. Coffman Funeral Home Inc</u>				25. REC'D BY REGISTRAR <u>MAY 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01330

RECEIVED 10-10-1961

1310

10-10-1961

[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07317

CERTIFICATE OF DEATH

07296

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 54 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS 425 Clarendon Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle Alice Last Head			4. DATE OF DEATH Month May Day 27 Year 19 67		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 20, 1899		9. AGE (In years last birthday) yrs. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY shoe mfg.		11. BIRTHPLACE (County & State, or foreign country) Timberville, Va.	
13. FATHER'S NAME John Gordon			14. MOTHER'S MAIDEN NAME Mary E. Lloyd		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-5671		17. INFORMANT James W. Head, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism Secondary DUE TO to cholecystectomy, cholelithiasis, DUE TO + Appendicitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 10 days 35 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr. 23, 1967 to May 27, 1967 , that (I) (we) last saw the deceased alive on May 27, 1967 , and that death occurred at 11:15 M, from causes and on the date stated above.					
22a. SIGNATURE Edward W. Ditto, III		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-29-67	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D.		22d. ADDRESS 217 W. Washington Street Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-31-67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.			25a. REC'D BY REGISTRAR JUN 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0.855

1152

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07318

07297

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md</u>		c. LENGTH OF STAY IN 1b <u>1 yr 8 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>		753	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holte Wood Church Home</u> <u>2750 Va Ave, Wmspt, Md.</u>				d. STREET ADDRESS <u>310 North Grant</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>May</u> Last <u>Hennenberger</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 30, 1881</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Reid, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James B. Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Barnhart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>183-07-4150</u>		17. INFORMANT <u>Martha Wagner, supt</u>		Address <u>2750 Va Ave Wmspt, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive cr. Disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 55</u> , 19 <u>65</u> , to <u>5-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-30</u> , 19 <u>67</u> , and that death occurred at <u>7:05</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Robert P. Conrad</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				22d. ADDRESS <u>Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Burial</u>		<u>5/3/67</u>		<u>Green Hill Cem.</u>		<u>Waynesboro Pa.</u>	
24. FUNERAL DIRECTOR <u>A. E. Mummich - Greencastle, Pa</u>				25a. REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

2157

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07313

CERTIFICATE OF DEATH

07298

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		21/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 522 REYNOLDS AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE MARY ELIZABETH HESS				4. DATE OF DEATH Month Day Year MAY 6, 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 19, 1901		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY LAWYERS OFFICE		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL S. McCLAIN				14. MOTHER'S MAIDEN NAME ELLEN LUSHBAUGH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-18-2624		17. INFORMANT MISS JEANETTE McCLAIN, 522 REYNOLDS AVE. HAGERSTOWN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of gallbladder 1551 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with local extension to DUE TO liver & pancreas (c) liver & pancreas						INTERVAL BETWEEN ONSET AND DEATH 1 week 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Signal perforation stomach						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. AGENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 13, 1967 , to May 6, 1967 , that (I) (we) last saw the deceased alive on May 6, 1967 , and that death occurred at 1:02 P.M. from causes and on the date stated above.							
22a. SIGNATURE Lawrence L. Packer, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED MAY 8, 1967	
22c. PHYSICIAN'S NAME (Type) DR. LAWRENCE L. PACKER, JR.				22d. ADDRESS 145 W. WASHINGTON ST. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/9/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25. RECD BY REGISTRAR MAY 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

03819

11002

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07320

07299

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maugansville, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>BAER</u> Last <u>HORST</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1877</u>
9. AGE (In years last birthday) yrs. <u>90</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Baer</u>		14. MOTHER'S MAIDEN NAME <u>Susanna Horst</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>S. Lester Horst</u>		Address <u>Maugansville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20, 1967</u> , to <u>May 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 15, 1967</u> , and that death occurred at <u>10:30pm</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		22b. DATE SIGNED <u>6-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	23b. DATE THEREOF <u>6/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reiff Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>near Cearfoss, Md.</u>
24. FUNERAL DIRECTOR <u>A. E. Munnich - Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 5 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
07321		CERTIFICATE OF DEATH		07300	
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt #6, HAGERSTOWN, MD.</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt #6, HAGERSTOWN, MARYLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>KING STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JODI</u> Middle <u>SUE</u> Last <u>HORST</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>INFANT</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15, 1967</u>	9. AGE (In years last birthday) yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON COUNTY, MD.</u>	
13. FATHER'S NAME <u>FRED LYNN</u>		14. MOTHER'S MAIDEN NAME <u>SHARON SUE KEADLE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7625 PRIMARY ATELECTASIS</u> DUE TO (b) <u>MARKED IMMATUREITY Birth wt. 18oz 4 HRS.</u> DUE TO (c) <u>Prematurity</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-15</u> , 19 <u>67</u> to <u>5-15</u> , 19 <u>67</u> that (I) <u>(was)</u> last saw the deceased alive on <u>5/15</u> 19 <u>67</u> , and that death occurred at <u>3:45</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Ronald E. Keyser</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD E. KEYSER</u>		22d. ADDRESS <u>101 King St. HAGERSTOWN</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>MAY 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON COUNTY HOSPITAL</u>		23d. LOCATION (City or Town)	(County) (State)
24. FUNERAL DIRECTOR <u>John B Schaffer, Adm. Wash Co Hosp</u>		25a. REC'D BY REGISTRAR <u>MAY 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

7-221538

1287

2001 2002

5

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07322

07301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS RFD 3	
3. NAME OF DECEASED (Type or print) SARAH JANE ELIZABETH HOSE		4. DATE OF DEATH Month May Day 18 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1929
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Dr.'s office	11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Ray Ford	
14. MOTHER'S MAIDEN NAME Naomi Maugans		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 214-28-1053		17. INFORMANT Fred T. Hose, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subsidiary emboli DUE TO acute myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3-4 weeks (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 19 52 to May 19 67 , that (I) (we) last saw the deceased alive on 5/18/67 19__, and that death occurred on 5/18/67 M, from causes and on the date stated above.			
22a. SIGNATURE John C. Morton		22b. DATE SIGNED 5/19/67	
22c. PHYSICIAN'S NAME (Type) John C. Morton		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-22-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SECRET

REMARKS OF THE

REMARKS OF THE

REMARKS OF THE

REMARKS OF THE

REMARKS OF THE

REMARKS OF THE

REMARKS OF THE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07323

CERTIFICATE OF DEATH

08761

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			c. LENGTH OF STAY IN it <u>3 Mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Rt. #1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>Dellinger Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>Hampton</u> Last <u>Howell</u>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1877</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Jefferson Co. Charles Town, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph R. Howell</u>				14. MOTHER'S MAIDEN NAME <u>Susan Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-54-0497</u>		17. INFORMANT Address <u>George Howell, Williamsport, Rt.#1, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>Several</u> days <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardio Vascular Disease</u> <u>5</u> years DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour _____ a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2-1-67</u> , 19 <u>67</u> , to <u>5-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-4-</u> 19 <u>67</u> , and that death occurred at <u>5:15 PM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>A. E. W. Ditto, Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>5-5-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				22d. ADDRESS <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Wash.Co., Md.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Andrew K. Coffman Funeral Home, Inc., Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

12751

RECORD OF DEATH

12751

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07324

CERTIFICATE OF DEATH

07302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND. b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 11 YEARS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL			e. STREET ADDRESS 331 BELVIEW AVENUE		
3. NAME OF DECEASED (Type or print) First ROY Middle PAUL Last HUBER			4. DATE OF DEATH Month MAY Day 8 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 27, 1890	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SCHOOL TEACHER			10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS		11. BIRTHPLACE (County & State, or foreign country) FOUNTAIN CITY, WISCONSIN
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME GEORGE HUBER		
14. MOTHER'S MAIDEN NAME EMMA GEBHART			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		
16. SOCIAL SECURITY NO. 219-36-4728			17. INFORMANT MRS. LINDA B. HUBER, 331 BELVIEW AVENUE, HAGERSTOWN, MARYLAND.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral thrombosis DUE TO (b) Arteriosclerosis - Gen. DUE TO (c) Pulmonary Emphysema					INTERVAL BETWEEN ONSET AND DEATH 2 days Yrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cholecystitis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Nov 12 , 19 57 , to May 8 , 19 67 , that (I) (we) last saw the deceased alive on May 8 , 19 67 , and that death occurred at 3 A.M. from causes and on the date stated above.					
22a. SIGNATURE Lloyd A. Hoffman			22b. DATE SIGNED MAY 9, 1967		
22c. PHYSICIAN'S NAME (Type) DR. LLOYD A. HOFFMAN, M.D.			22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/10/67	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.		
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.			25a. REC'D BY REGISTRAR MAY 12 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

4353

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Berkeley</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIA MARGARET ISEMINGER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27 1890</u>
9a. AGE (In years last birthday) <u>76</u> yrs.		9b. IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Drenner</u>		14. MOTHER'S MAIDEN NAME <u>Clara Kline</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-50-7748</u>	
17. INFORMANT <u>Mr. H. Russell Iseminger</u>		Address <u>Harpers Ferry RFD #1 W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolic Thrombosis</u> <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generally 5 arterial branches</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-7-1965</u> to <u>5-15-1967</u> , that (I) (we) last saw the deceased alive on <u>5-15-1967</u> , and that death occurred at <u>7:00</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>H. Russell Iseminger</u>		22b. DATE SIGNED <u>5-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECUNDARI</u>		22d. ADDRESS <u>ROOMS B.R. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 18-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sharpsburg Md.</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 19 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00000



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07326

CERTIFICATE OF DEATH

07304

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro	
c. LENGTH OF STAY IN 1b 10 Days		75.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 312 W. Third St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Naomi C. Kauffman		4. DATE OF DEATH Month Day Year May 16 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/1901
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Emmitsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Bowling		14. MOTHER'S MAIDEN NAME Gertrude Goulden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 173-03-0913B	
17. INFORMANT Mr. Chester B. Kauffman Sr.,		Address Waynesboro Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of colon & metastases 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Hypertensive heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-6, 1964 , to 5/16, 1967 , that (I) (we) lost the deceased alive on 5/16, 1967 , and that death occurred at 6:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE John H. Hurn Baker		22b. DATE SIGNED 5/17/67	
22c. PHYSICIAN'S NAME (Type) JOHN H. HURNBAKER		22d. ADDRESS 127 W. WASHINGTON ST. HAGERSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/67	
23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin Co., Pa.	
24. FUNERAL DIRECTOR Walter J. Hove		25a. REC'D BY REGISTRAR Waynesboro Pa.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 22 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

012350

UNITED STATES OF AMERICA

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07327

CERTIFICATE OF DEATH

08764

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 14 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hagerstown R. D. 5		d. STREET ADDRESS 21-1	
3. NAME OF DECEASED (Type or print) First Wilbur Middle Kelso Last Kauffman		4. DATE OF DEATH Month May Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1887
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heating Contractor		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (County & State, or foreign country) Crawford Co., Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. Kauffman		14. MOTHER'S MAIDEN NAME Ida M. Bonebrake	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 171-28-6401A	
17. INFORMANT Mrs. Wilbur K. Kauffman		Address Hagerstown #5, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma (Site of origin undetermined) 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April , 1967, to May 30 , 1967, that (I) (we) last saw the deceased alive on May 29 , 1967, and that death occurred at 24 M, from causes and on the date stated above.			
22a. SIGNATURE Charles Spencer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED May 31, 67
22c. PHYSICIAN'S NAME (Type) Dr. Charles Spencer		22d. ADDRESS 1145 S. Prospect St. Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/1/1967	23c. NAME OF CEMETERY OR CREMATORY Green Hill	23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Pa.
24. FUNERAL DIRECTOR Walter J. Lutz		25a. REC'D BY REGISTRAR Waynesboro, Penna.	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07357

ESTIMATE OF COST

IN THE MATTER OF THE ESTATE OF JAMES H. HARRIS, DECEASED

ADMINISTRATOR'S REPORT

FILE NO. 100-100000

REPORT OF THE ADMINISTRATOR

RECEIVED BY THE COURT

FILED IN THE COURT

AT THE CITY OF NEW YORK

IN WITNESS WHEREOF, I HAVE HEREUNTO SET MY HAND AND SEAL

AT NEW YORK, NEW YORK

THIS 10TH DAY OF MAY, 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07328

CERTIFICATE OF DEATH

07305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 10 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 217	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 1 Cheryl Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alma Middle Lee Last Ketterman				4. DATE OF DEATH Month May Day 27 Year 19 67			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 9, 1914	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Hinton, Va.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher				10b. KIND OF BUSINESS OR INDUSTRY public school		11. BIRTHPLACE (County & State, or foreign country) Hinton, Va.	
13. FATHER'S NAME Harry Kiser				14. MOTHER'S MAIDEN NAME Shirley Trumbo			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 531-26-8356		17. INFORMANT Address Josiah Ketterman, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1750 IMMEDIATE CAUSE (a) Cancer of Ovary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-6-66 , 19 66 , to 5-27 , 19 67 ; that (I) (we) last saw the deceased alive on 5/27 , 19 67 , and that death occurred at 5 M, from causes and on the date stated above.							
22a. SIGNATURE J.R. Dwyer MD				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/27/67	
22c. PHYSICIAN'S NAME (Type) J.R. Dwyer				22d. ADDRESS 119 King St Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-29-67		23c. NAME OF CEMETERY OR CREMATORY Brandywine Cemetery		23d. LOCATION (City or Town) (County) (State) Brandywine, W. Va.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE MAY 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

0-10-10

0-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

79

3

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #16 Film #G388 5/19/67 DC

07329

CERTIFICATE OF DEATH

07306

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 30 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Md.		211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		d. STREET ADDRESS Rural Clear Spring, Md.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Roy Franklin Kline		4. DATE OF DEATH Month May Day 7 Year 19 67	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH June 26, 1912	
9. AGE (In years lost birthday) yrs. 54		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Kline		14. MOTHER'S MAIDEN NAME Mellissa Naille	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 218-22-1528	
17. INFORMANT Mrs Catharine Kline, Clear Spring, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO (b) Embolic DUE TO (c) Thrombotic formation on Aortic arch		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 mon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Rheumatic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1963 to 5/7/67 , 19 67 , that (I) (we) last saw the deceased alive on 5/7/67 19 67 , and that death occurred at 7 P.M. from causes and on the date stated above.			
22a. SIGNATURE John C. Norton		22b. DATE SIGNED 5/8/67	
22c. PHYSICIAN'S NAME (Type) John C. Norton		22d. ADDRESS Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/10/67	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Margaret Rowland		25a. REC'D BY REGISTRAR MAY 12 1967	
ADDRESS Clear Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

15850

noting that

205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07330

CERTIFICATE OF DEATH

07307

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro		c. LENGTH OF STAY IN 1b 5 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fahrney- Keedy Memorial Home		d. STREET ADDRESS N. Main St.	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Eugenia Lakin		4. DATE OF DEATH Month Day Year May 31, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1874
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 8 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Boonsboro, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME A. William Lakin		14. MOTHER'S MAIDEN NAME Josephine Troup	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 214-46-5850	
17. INFORMANT Robert E. Lakin, Boonsboro, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A. Senecarcinoma of breast - 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-23- , 19 59 , to 5-31- , 19 67 , that (I) (we) last saw the deceased alive on 5-31- , 19 67 , and that death occurred at 4:30 P. M, from causes and on the date stated above.			
22a. SIGNATURE Joseph Secomdari		22b. DATE SIGNED 6-1- 67	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECOMDARI		22d. ADDRESS Boonsboro Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-3- 67	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR JUN 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

00000

VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

22c. PHYSICIAN'S
NAME (Type)

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

24. FUNERAL DIRECTOR

CERTIFICATE OF DEATH

07331

07308

1. PLACE OF DEATH a. COUNTY <div>Washington</div> <div>MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <div>Pa.</div> <div>Franklin</div> <div>Waynesboro Pa.</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Hagerstown</div>		c. LENGTH OF STAY IN 1b <div>1 Year</div>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div>Jackson Conv. Home</div>		d. STREET ADDRESS <div>509 W. Main St.</div>	
3. NAME OF DECEASED (Type or print) <div>First Annie</div> <div>Middle E.</div> <div>Last Leedy</div>		4. DATE OF DEATH <div>Month May</div> <div>Day 25</div> <div>Year 1967</div>	
5. SEX <div>Female</div>	6. COLOR OR RACE <div>White</div>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div>12/16/1884</div>
9. AGE (In years last birthday) <div>82</div>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div>House Duties</div>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <div>Manheim, Waynesboro #2 Pa.</div>		12. CITIZEN OF WHAT COUNTRY? <div>U.S.A.</div>	
13. FATHER'S NAME <div>Samuel Rock</div>		14. MOTHER'S MAIDEN NAME <div>Emma Baker</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div>No</div>		16. SOCIAL SECURITY NO. <div>173-03-1665</div>	
17. INFORMANT <div>Address 509 W. Main St. Mr. Ned R. Leedy, Waynesboro Pa.</div>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <div>193X</div> <div>IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</div> <div>malnutrition</div>		INTERVAL BETWEEN ONSET AND DEATH <div>see below</div>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <div>malnutrition</div>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <div>19</div>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <div>June</div> , 19 <div>66</div> , to <div>May</div> , 19 <div>67</div> , that (I) (we) last saw the deceased alive on <div>5/17</div> , 19 <div>67</div> , and that death occurred at <div></div> M, from causes on and on the date stated above			
22a. SIGNATURE <div>Howard N. Weeks</div>		22b. DATE SIGNED <div>5/25/67</div>	
22c. PHYSICIAN'S NAME (Type) <div>Howard N. Weeks, M.D.</div>		22d. ADDRESS <div>580 Northern Ave. Hagerstown, Md.</div>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <div>Burial</div>		23b. DATE THEREOF <div>5/27/67</div>	
23c. NAME OF CEMETERY OR CREMATORY <div>Green Hill</div>		23d. LOCATION (City or Town) (County) (State) <div>Waynesboro, Franklin Co., Pa.</div>	
24. FUNERAL DIRECTOR <div>Walter J. Grove</div>		25a. REGISTRY BY REGISTRAR <div>1967</div>	
25b. REGISTRAR'S SIGNATURE <div>Walter J. Grove</div>		DATE <div></div>	

1937
1234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07332

07309

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>W.Va.</u> b. COUNTY <u>MORGAN</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY in 1b <u>40 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERKELEY SPRINGS</u> 85-3			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON CO. HOSPITAL</u>				d. STREET ADDRESS <u>R.F.D. #2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TRACY</u> Middle <u>HERMAN</u> Last <u>LINTZ</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-90</u> 76 yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MORGAN Co., W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>PETER LINTZ</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE DUCKWALL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>235-16-3990</u>		17. INFORMANT <u>Mrs. T. H. LINTZ - Berkeley Springs, W.Va.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>452x</u> DUE TO <u>Ruptured iliac artery aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>+ hemorrhage</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/13/67</u> , 19____, to <u>5/19/67</u> , 19____, that (I) (we) last saw the deceased alive on <u>5/19/67</u> , 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas V. Craig</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas V. Craig, M. D.</u>				22d. ADDRESS <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DUCKWALL</u>		23d. LOCATION (City, town or county) (State) <u>BERKELEY SPRINGS, W.Va.</u>		
24. FUNERAL DIRECTOR <u>WM. H. HUNTER</u>				25a. REC'D BY REGISTRAR <u>BERKELEY SPRINGS, W.Va.</u>		25b. REGISTRAR'S SIGNATURE <u>William Hunter</u>	

07332

May 19. 07
 9-6-10 75
 Peter Lint
 American
 May 19. 07
 9-6-10 75
 Peter Lint
 American

+ removed
 captured state city council
 heart failure

2/24/07

X

Thomas Craig

James H. Hume
 James H. Hume
 James H. Hume

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07310

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 60			c. LENGTH OF STAY IN 1b ?	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXXXX Rt5 Leightersburg			211
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Route 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patrick Middle Owen Last Lloyd				4. DATE OF DEATH Month May Day 24 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1967		9. AGE (In years lost birthday) yrs. 21	IF UNDER 1 YEAR Months 2 Days 16	IF UNDER 24 HRS. Hours 16 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Lee Lloyd				14. MOTHER'S MAIDEN NAME Yvonne E. Winterstine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Frank Winterstine, Rt.4 Cumberland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain damage from fractured skull 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-auto collision on Rt. 60, Wash. Co., Md.					
20c. TIME OF INJURY Month, Day, Year Hour 12:15 pm 5/24 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Hagerstown Wash. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Howard N. Weeks, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 5/25/67 EXAMINER'S NAME (Type) Howard N. Weeks, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 27, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Md. Allegany	
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

7-227387

100000

THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07311

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 624 WEST FRANKLIN STREET,	
3. NAME OF DECEASED (Type or print) First ERNEST Middle FRANKLIN Last MARTIN		4. DATE OF DEATH Month MAY Day 14 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 2, 1914
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) WASHINGTON CO. MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY E. MARTIN		14. MOTHER'S MAIDEN NAME CARRIE FOUKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO *****		16. SOCIAL SECURITY NO. 214-09-6495	
17. INFORMANT MRS. REBA C. MARTIN,		624 W. FRANKLIN ST. HAGERSTOWN, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerosis, generalized and DUE TO Arteriosclerotic heart disease DUE TO Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 18-20 hrs 10-15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto M.D.		22. DATE SIGNED 5/16/67	
EXAMINER'S NAME (Type) DR. EDWARD W. DITTO, III M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/18/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY,	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR MAY 19 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1875

1875

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1875

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1874

ALBANY:

1875

PRINTED BY

THE STATE PRINTING OFFICE

ALBANY

1875

1875

1875

1875

1875

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove green papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07335

CERTIFICATE OF DEATH

07312

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		21/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 957 VIEW STREET,		d. STREET ADDRESS 957 VIEW STREET,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LEWIS AUGUSTIN MARTIN		4. DATE OF DEATH Month Day Year MAY 4, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 29, 1895
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MANAGER		10b. KIND OF BUSINESS OR INDUSTRY PEOPLES DRUG STORE	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN D. MARTIN		14. MOTHER'S MAIDEN NAME HENRIETTA HANN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. # 1		16. SOCIAL SECURITY NO. 214-09-0207 A	
17. INFORMANT MRS. MYRA C. MARTIN,		Address 957 VIEW STREET, HAGERSTOWN, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerotic Heart Disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from 11-26 , 19 67 , to 5-4 , 19 67 , that (I) (we) lost saw the deceased alive on 5-4-1967 , and that death occurred at 1 P. M, from causes and on the date stated above.			
22a. SIGNATURE Dalton M. Welby		22b. DATE SIGNED MAY 6, 1967	
22c. PHYSICIAN'S NAME (Type) DR. DALTON M. WELBY, M.D.		22d. ADDRESS 998 POTOMAC AVE. HAGERSTOWN, MARYLAND.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/8/67	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY,		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER,		25a. REC'D BY REGISTRAR May 9 1967	
ADDRESS HAGERSTOWN, MARYLAND.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1000

STATE OF NEW YORK

1000

IN SENATE
JANUARY 10, 1900

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY: J.B. LEECH, STATE PRINTER, 1900.

THE COMMISSIONERS OF THE LAND OFFICE

ALBANY, N.Y., JANUARY 10, 1900.

SIR: I have the honor to acknowledge the receipt of your letter of the 2nd inst.

in relation to the matter of the purchase of the land for the

purpose of the construction of the canal.

I am sorry to hear that you are unable to obtain the land for the

purpose of the construction of the canal.

I am, however, glad to hear that you are able to obtain the land for the

purpose of the construction of the canal.

I am, however, glad to hear that you are able to obtain the land for the

purpose of the construction of the canal.

I am, however, glad to hear that you are able to obtain the land for the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07336 CERTIFICATE OF DEATH 07313

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN ID <u>2 days.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown RFD #4</u> d. STREET ADDRESS <u>RFD# 4</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Peter</u> <u>Leshner</u> <u>Martin</u>		4. DATE OF DEATH <u>May</u> <u>30</u> <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4 1888</u>
9. AGE (in years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR <u>11</u> Months <u>25</u> Days	IF UNDER 24 HRS. <u>Hours</u> <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. d Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (County & State, or foreign country) <u>State .ine Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>David H Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Eshelman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217 10 2691</u>		17. INFORMANT <u>Mrs. Helen Shank Martin</u> Address <u>Hagerstown Md.. RFD #4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 4200 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>3 yrs</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6/30</u>	
20f. (City or town) <u>65</u> (County) <u>5/30</u> (State) <u>67</u>		21. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> , 19 <u>67</u> to <u>6/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> , 19 <u>67</u> , and that death occurred at <u>3:40</u> M, from the causes and on the date stated above.	
22a. SIGNATURE <u>Donald E. Martin</u>		22b. DATE SIGNED <u>5/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald E. Martin, M.D.</u>		22d. ADDRESS <u>418 N. Potomac St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 2-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor Lutheran Cemetery</u>		23d. LOCATION (City, town or county) <u>Fairview Maryland</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

1918

STATE OF NEW YORK

1918

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "State of New York" and "1918" are visible.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07337

07314

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS Falling Waters Road	
3. NAME OF DECEASED (Type or print) First VIRGINIA Middle NANCY Last MAUCK		4. DATE OF DEATH Month May Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1910
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 4 Days 26 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Peter Ruffner		14. MOTHER'S MAIDEN NAME Rebecca Sweitzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr.. Russell R. Mauck		Address Williamsport Maryland RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carotid aneurism (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pancreatic hemorrhage			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1201 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 2 , 19 59 , to May 25 , 19 67 , that (I) (we) last saw the deceased alive on May 24 19 67 , and that death occurred at 12:01 P.M. from the causes and on the date stated above.			
22a. SIGNATURE M. E. Byrkit, M. D.		22b. DATE SIGNED May 26, 1967	
22c. PHYSICIAN'S NAME (Type) M. E. Byrkit, M. D.		22d. ADDRESS 28 West Potomac Street Williamsport, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 28 1967	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City, town or county) (State) Williamsport Maryland
24. FUNERAL DIRECTOR Albert L.. Leaf Williamsport Md.		25a. REC'D BY REGISTRAR MAY 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

OFFICE OF DEAN

00000

100.00.00

100.00.00

100.00.00

X

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07338

07315

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md.		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg		21-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Newton		First Snively		Last McCarney		4. DATE OF DEATH Month May Day 12 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH October 4, 1891			
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months 75		11. IF UNDER 24 HRS. Hours 75		12. IF UNDER 24 HRS. Min. 75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter		10b. KIND OF BUSINESS OR INDUSTRY Painter		11. BIRTHPLACE (State or foreign country) Mt. Hope, Adams Co., Pa.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Levi Baldwin McCarney				14. MOTHER'S MAIDEN NAME Sarah Ann Watson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 173-03-3534A		17. INFORMANT Address Mrs. Alice M. Thomas, Blue Ridge Summit, Pa.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli, Bilateral 466X DUE TO (b) Phlebotrombosis, Left & lower Extremity DUE TO (c) 29-4th Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 10-30 Hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Aspiration of Gastric Fluid								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Edward W. Ditto III				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME Edward W. Ditto III				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 217 W. Washington St. Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 15, 1967		22c. NAME OF CEMETERY OR CREMATORY Marsh Creek Cemetery		22d. LOCATION (City, town, or country) Gettysburg Pa.			
23. FUNERAL DIRECTOR Minnich Funeral Home, Smithsburg, Maryland				24a. REC'D BY REGISTRAR MAY 19 1967					
				24b. REGISTRAR'S SIGNATURE Charles Judge					

07338

07338

London Travel Home, Southampton, England

Mr. Edward W. Dike
General Agent

21 W. Washington St.
Chicago, Ill.

Registration of Gothic Fluid

Chicago, Ill. 10. 10. 10.
Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

Chicago, Ill. 10. 10. 10.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07339

Item 9 Film G389 5/25/67 kk

CERTIFICATE OF DEATH

07316

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 212 TERRACE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME				d. STREET ADDRESS HANCOCK MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN HERMAS MCGOWAN				4. DATE OF DEATH Month Day Year 5 14 19 67			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8.1.1920		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MORGAN COUNTY W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W MCGOWAN				14. MOTHER'S MAIDEN NAME MINNIE M EVERSOLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 11		16. SOCIAL SECURITY NO. 235.16.8108		17. INFORMANT Address LLOYD G MCGOWAN 212 TERRACE HANCOCK MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Cardiac arrest DUE TO (b) Myocardial Infarction DUE TO (c) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Heavy smoker & drinker							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan 9, 1967, to 4-27-1967 that (1) (we) last saw the deceased alive on 4-27-1967, and that death occurred at M, from causes and on the date stated above.							
22a. SIGNATURE Charles R Wierer M.D.				22b. DATE SIGNED 5-16-67		22c. PHYSICIAN'S NAME (Type) Charles R. Wierer, M.D.	
22d. ADDRESS 238 E. Main St., Hancock, Md.		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5.18.67		23c. NAME OF CEMETERY OR CREMATORIUM GREAT CAPON		23d. LOCATION (City or Town) (County) (State) GREAT CAPON MORGAN W.VA.	
24. FUNERAL DIRECTOR Hansel F. Elmore Hancock Md				25a. REC'D BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

07339

3660

EXHIBIT IN DEATH

WASHINGTON

WASHINGTON

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07340

CERTIFICATE OF DEATH

07317

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Penna. b. COUNTY Fulton ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McConnellsburg	
c. LENGTH OF STAY IN TB 5 days		d. STREET ADDRESS Lincoln Way, E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLAUDE LIONEL MELLOTT		4. DATE OF DEATH Month May Day 10 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1903
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY insurance Co.	
11. BIRTHPLACE (County & State, or foreign country) Webster Mills, Pa.		12. CITIZEN OF WHAT COUNTRY? Pa.	
13. FATHER'S NAME Gilbert B. Mellott		14. MOTHER'S MAIDEN NAME Leticia Whitfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Elena V. Mellott, McConnellsburg, Pa	
17. INFORMANT Elena V. Mellott, McConnellsburg, Pa		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction with embolus 4201 DUE TO (b) coronary artery disease DUE TO (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH minutes years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) prostatic hypertrophy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 11 May, 1967 , that (I) (we) last saw the deceased alive on 10 May 19 67 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John C. Stauffer		22b. DATE SIGNED 5-11-67	
22c. PHYSICIAN'S NAME (Type) John C. Stauffer		22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-14-67	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City or Town) (County) (State) McConnellsburg, Pa.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAY 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1934

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

CLAUDE LIGNET MELLOTT

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07341											
07318											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>211</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u>						d. STREET ADDRESS <u>417 Brewer Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>H.</u> Last <u>Milburn</u>						4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 24, 1872</u>		9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store Owner</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cedarville, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>James Milburn</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Catherine Grove</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Agnes Suncine, Hagerstown, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>indefinite</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>Hour</u> <u>min.</u> <u>p.m.</u> <u>19</u>				20d. INJURY OCCURRED <u>While</u> <u>Not While</u> <u>at work</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>3-27, 1967</u> that (I) (we) last saw the deceased alive on <u>3-27, 1967</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert F. Keadle</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-29-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle, M. D.</u>						22d. ADDRESS <u>580 Northern Ave., Hagerstown, Md 21740</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/30/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington Co. Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. Zimmerman, Hagerstown, Pa</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE		DATE <u>MAY 31 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07342

CERTIFICATE OF DEATH

07319

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 5 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown			21-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Rfd. 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle Ann Last Miller				4. DATE OF DEATH Month May Day 20 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 10, 1907		9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months 11 Days 10 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Leonard				14. MOTHER'S MAIDEN NAME Harriet Ellen Barthlow			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 187-16-6108		17. INFORMANT Address Ma. Mr. George E. Miller, Rfd. 3 Hagerstown,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of bladder & rectum 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 39 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 16, 1967 , to May 20, 1967 , that (I) (we) last saw the deceased alive on May 20, 1967 , and that death occurred at 11A M, from causes and on the date stated above.							
22a. SIGNATURE <i>G. W. Levan</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.O. _____		22b. DATE SIGNED 5/21/67	
22c. PHYSICIAN'S NAME (Type) G. W. Levan		22d. ADDRESS Boonsboro, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-67	23c. NAME OF CEMETERY OR CREMATORY Tuscarora Cemetery		23d. LOCATION (City or Town) (County) (State) Rural Martinsburg, W. Va.		
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR MAI 25 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1937

RECEIVED BY THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315

OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315

MEMORANDUM FOR THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

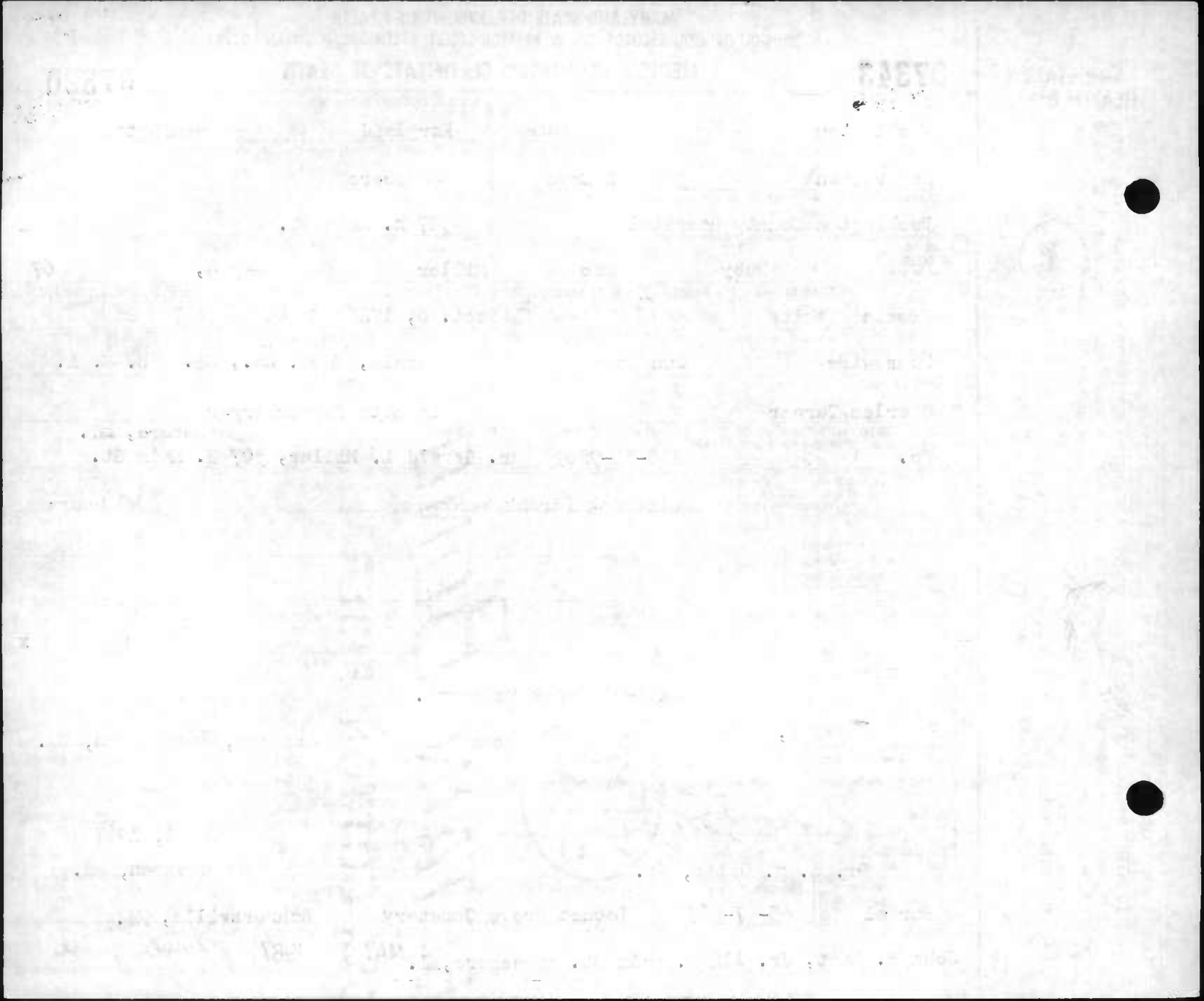
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07320

1. PLACE OF DEATH o. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS 307 N. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ruby Mae Miller			4. DATE OF DEATH Month Day Year May 4, 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1926		9. AGE (In years last birthday) yrs. 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Benevola, Wash. Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Charles Turner		
14. MOTHER'S MAIDEN NAME Lovetta Poffenberger			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		
16. SOCIAL SECURITY NO. 218-30-9809			17. INFORMANT Boonsboro, Md. Mr. Gerald L. Miller, 307 N. Main St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 971.8 Poisoning (drank kerosene) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient drank kerosene.			
20c. TIME OF INJURY Month, Day, Year 2 Hour May 2, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Boonsboro, Washington, Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE J. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 6, 1967	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-7-67		23c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery	
23d. LOCATION (City or Town) Rohrersville, Md.		23e. (County) (State)			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07344

CERTIFICATE OF DEATH

07321

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK			c. LENGTH OF STAY IN 1b LIFE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL 2, HANCOCK				d. STREET ADDRESS RURAL 2, HANCOCK			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HILLARD WILSON MILLS				4. DATE OF DEATH Month Day Year MAY 21, 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/1910		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (County & State, or foreign country) WASH. CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL MILLS				14. MOTHER'S MAIDEN NAME CELIA HULL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-09-9261		17. INFORMANT Address VIRGINIA SHOEMAKER RFD 2, HANCOCK MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - Asphyxiation 5020 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Advanced Emphysema & Asthmatic Bronchitis (b) Pulmonary Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) intermittent heavy alcohol intake							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23, 1966 to June 16, 1966 that (I) (we) last saw the deceased alive on June 16, 1966 , and that death occurred at 7:40 P.M. from causes and on the date stated above.							
22a. SIGNATURE Charles R. Wierer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 25, 1967	
22c. PHYSICIAN'S NAME (Type) Charles R. Wierer, M. D.				22d. ADDRESS 238 E. Main St., Hancock, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/25/67		23c. NAME OF CEMETERY OR CHURCH ORCHARD RIDGE 1ST CH.		23d. LOCATION (City or Town) (County) (State) RURAL HANCOCK WASH., MD.	
24. FUNERAL DIRECTOR RICHARD J. GROVE HANCOCK, MARYLAND				25a. REC'D BY REGISTRAR MAY 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

03364

WASHINGTON

RURAL HANCOCK

RURAL S. HANCOCK

HILL AND

WIFE WHITE

LAGORCH

CARTEL KILLS

40

CONSTRUCTION

CELEA BULL

MAY

11/25/10

ELSON

MARYLAND

RURAL HANCOCK

RURAL S. HANCOCK

WASH. CO., MARYLAND

250-02-4801 VIRGINIA BRICKLAKEN RD S, HANCOCK MD.

XXXXX

RURAL

2/25/05

HIGLAND J. GROVE HANCOCK, MARYLAND

ORCHARD RIDGE 1ST CH. RURAL HANCOCK WASH. MD.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07345

07322

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Keedysville		c. LENGTH OF STAY IN TB 6 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5 N. Main Street		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Keedysville 21-1	
3. NAME OF DECEASED (Type or print) Charles Earl Moats		4. DATE OF DEATH May 5 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10 1929
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Air Craft	
11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Willard Moats		14. MOTHER'S MAIDEN NAME Pauline Cottrill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212 26 4406	
17. INFORMANT Mrs.. Vivian Arlene Moats		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Spontaneous Circumflex Lc. of Lt 4201 DUE TO (b) Coronary Artery DUE TO (c) Severe Coronary atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10-15m	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Edward W. Ditto 3rd.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto 3rd.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 8-67	
22c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville Maryland	
23. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport Maryland	
24a. REC'D BY REGISTRAR MAY 9 1967		24b. REGISTRAR'S SIGNATURE J. Charles Judge	

1. Name of Deceased: *John William Smith*
2. Age: *45*
3. Sex: *Male*
4. Date of Death: *May 10, 1917*
5. Place of Death: *Home*
6. Cause of Death: *Heart Disease*
7. Manner of Death: *Natural*
8. Signature of Medical Examiner: *John W. Smith*
9. Signature of Coroner: *John W. Smith*
10. Signature of Registrar: *John W. Smith*

11. Name of Physician: *John W. Smith*
12. Address of Physician: *123 Main St.*
13. Name of Hospital: *St. Mary's Hospital*
14. Address of Hospital: *456 Main St.*
15. Name of Undertaker: *John W. Smith*
16. Address of Undertaker: *789 Main St.*
17. Name of Burial Place: *St. Mary's Cemetery*
18. Address of Burial Place: *101 Main St.*
19. Name of Minister: *John W. Smith*
20. Address of Minister: *111 Main St.*

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07346 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07323

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>72 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>258 S. Locust St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>258 S. Locust St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Beatrice</u> Last <u>Mongan</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1895</u>
9. AGE (in years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>21</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harvey Kridler</u>		14. MOTHER'S MAIDEN NAME <u>Ida Chaplin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Faith Olive Vincent</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		M.D. <u>5/22/67</u>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		22. DATE SIGNED <u>5/22/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/23/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR <u>Minnich Funeral Home, Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 26 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07347

CERTIFICATE OF DEATH

07324

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Knoxville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 10-2	
3. NAME OF DECEASED (Type or print) John R. Monroe		4. DATE OF DEATH Month 5 Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/17/91
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months) Employment Agency, Inc. Hagerstown		10b. KIND OF BUSINESS OR OCCUPATION Custodian	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-14-4992-A	
17. INFORMANT Mrs. Anna G. Monroe		Address Knoxville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7571 IMMEDIATE CAUSE (a) Uremia DUE TO (b) Renal upt and stating the underlying cause last. (c) Renal infarct		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John J. Donoghue		22b. DATE SIGNED 5-26-67	
22c. PHYSICIAN'S NAME (Type) John J. Donoghue		22d. ADDRESS 360 Northern Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/29/67	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Petersville Md
24. FUNERAL DIRECTOR Teete Funeral Home		25a. REC'D BY REGISTRAR DATE MAY 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

UNITED STATES DEPARTMENT OF AGRICULTURE

1907

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

REPORT OF THE SECRETARY

FOR THE YEAR 1907

AND THE PROGRESS OF THE DEPARTMENT

IN THE YEAR 1907

AND THE PROGRESS OF THE DEPARTMENT

IN THE YEAR 1907

AND THE PROGRESS OF THE DEPARTMENT

IN THE YEAR 1907

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA FORM 10-66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07348

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07325

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>21 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>406 Linganore, Ave.</u>		d. STREET ADDRESS <u>406 Linganore, Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>Kathleen</u> Last <u>Murray</u>		4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1901</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Joseph G. Zimmerman</u>		16. MOTHER'S MAIDEN NAME <u>Bertha Arbelia Baker</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>214-09-0693</u>	
19. INFORMANT <u>Mr. D.C. Murray</u>		Address <u>406 Linganore Ave. Hagerstown, Md.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basal skull fracture and broken neck</u> DUE TO (b) <u>sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>978X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt. was depressed and under psychiatric care</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. climbed out of third-story window and fell to concrete sidewalk</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>2-4 xx 5/26 67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H.N. Weeks</u>		M.D. <u>H.N. Weeks, M.D.</u>	
EXAMINER'S NAME (Type) <u>H.N. Weeks, M.D.</u>		22. DATE SIGNED <u>5/26/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/28/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. Cantor</u>		ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>	
25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

25883

Wm. G. Carter

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07349

CERTIFICATE OF DEATH

07326

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME		d. STREET ADDRESS RURAL 2	
3. NAME OF DECEASED (Type or print) First MARIE Middle ELIZABETH Last MYERS		4. DATE OF DEATH Month 5 Day 4 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.11.15
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) FULTON COUNTY PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OLIVER M DIVELBLISS		14. MOTHER'S MAIDEN NAME IVY DESHONG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT PAUL H MYERS RURAL 2 HANCOCK MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO ASHD (b) Diabetes Mellitus DUE TO Diabetes Mellitus (c) Obesity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		INTERVAL BETWEEN ONSET AND DEATH 1 hr 12 yrs 6 yrs	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/13/67 , 19__, to 4/14/67 , 19__, that (I) (we) last saw the deceased alive on 4/14/67 , 19__, and that death occurred at 10:30 P M, from causes and on the date stated above.			
22a. SIGNATURE FB Thomas III MD		22b. DATE SIGNED 5/8/67	
22c. PHYSICIAN'S NAME (Type) FB Thomas III MD		22d. ADDRESS Hancock, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5.8.67	23c. NAME OF CEMETERY OR CREMATOR CEDAR LAWN MEMORIAL	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD
24. FUNERAL DIRECTOR Houderal & Stone Hancock Md		25a. REC'D BY REGISTRAR MAY 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01650

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07350

CERTIFICATE OF DEATH

07327

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Loudon</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>19</u> Years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Homewood Church Home Inc</u>				d. STREET ADDRESS <u>Route # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>LAVENIA</u> Last <u>MYERS</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>June 2 1896</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Waterford Loudon Co Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Edward Myers</u>				14. MOTHER'S MAIDEN NAME <u>Essie Lathan Rollins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>230-30-7701A</u>		17. INFORMANT <u>Mark G. Wagner</u> Address <u>2570 Virginia Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u>21795</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-15-67</u> to <u>5-21-67</u> , that (I) (we) last saw the deceased alive on <u>5-21-67</u> , and that death occurred at <u>10:00</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>E.W. Ditto Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E.W. Ditto Jr</u>				22d. ADDRESS <u>215 W. Washington St Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Lovetttsville Loudon Co Va</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> <u>Hagerstown Md</u> ADDRESS <u>Funeral Home Inc</u>				25a. REC'D BY REGISTRAR <u>MAY 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03370

CERTIFICATE OF DEATH

State of New York, County of ...

On the ... day of ... 19...

at ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Item 18 Film 389 6-12-67 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07351

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07328

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 350 E. Washington St.		d. STREET ADDRESS 350 E. Washington St.	
3. NAME OF DECEASED (Type or print) Elmer Leroy Obitts		4. DATE OF DEATH Month May Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7-1908
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Williamsport- Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Obitts		14. MOTHER'S MAIDEN NAME Stella Wolfe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWar 11		16. SOCIAL SECURITY NO. 217-07-7459	
17. INFORMANT Mrs. Eliz. I. Obitts-		Address Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Thrombotic occlusion anterior DUE TO descending Lt & Rt coronary artery (b) Plaque rupture DUE TO Severe coronary atherosclerosis (c) Aspiration of gastric contents		INTERVAL BETWEEN ONSET AND DEATH 30-60 min 10-15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration of gastric contents		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		22. DATE SIGNED 5-15-67	
EXAMINER'S NAME (Type) DR. EDWARD W. DITTO III		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 17-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR Whitmore DATE MAY 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

07351

Washington
Department of the Interior
Bureau of Land Management
Washington, D.C.

320 A. Washington St.
Washington, D.C.
May 15, 1961

Mr. J. Edgar Hoover
Federal Bureau of Investigation
Washington, D.C.

Dear Mr. Hoover:
I am writing to you regarding the matter of the
1961-1962 season.

I am writing to you regarding the matter of the
1961-1962 season.

DR EDWARD W. DITTO III
217 W. WASHINGTON ST., HAG. MD.

Respectfully,
Edward W. Ditto III

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07352						07329					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN ID <u>4 weeks</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> <u>21.1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						d. STREET ADDRESS <u>313 E. Frederick Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THELMA AMELIA PALMER</u>						4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 23 1909</u>		9. AGE (In years last birthday) <u>57</u> yrs. Months <u>6</u> Days <u>9</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>David Walt Young</u>						14. MOTHER'S MAIDEN NAME <u>Anna May Little</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-----</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Van D. Palmer</u> Address <u>13 E. Frederick Street Williamsport Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Tumor (left)</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>6mo 3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 29</u> , 19 <u>65</u> , to <u>May 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 3</u> , 19 <u>67</u> , and that death occurred at <u>8:30M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>M. E. Byrkit</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 4, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit, M. D.</u>						22d. ADDRESS <u>28 West Potomac Street, Williamsport, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>May 6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland</u>			
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport, Maryland</u>						25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

03325

RECEIVED 10 3 1959

10 3 1959

10 3 1959
10 3 1959
10 3 1959

(10 3 1959)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07353

CERTIFICATE OF DEATH

07330

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 55 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 935 THE TERRACE	
3. NAME OF DECEASED (Type or print) First THOMAS Middle WESLEY Last PANGBORN		4. DATE OF DEATH Month MAY Day 20 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 29, 1880
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PRESIDENT		10b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING FIRM	
11. BIRTHPLACE (County & State, or foreign country) BROOKLYN, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES T. PANGBORN		14. MOTHER'S MAIDEN NAME ANNA MORRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 214-09-5943	
17. INFORMANT MRS. HELEN FISHER,		Address 635 OAK HILL AVE. HAGERSTOWN, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC C-V disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 4 days 20 YRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Nov. , 1965, to MAY 20 , 1967, that (I) (we) last saw the deceased alive on MAY 20 , 1967, and that death occurred at 9:30 AM , from causes and on the date stated above.			
22a. SIGNATURE John A. Moran		22b. DATE SIGNED MAY 22, 1967	
22c. PHYSICIAN'S NAME (Type) DR. JOHN A. MORAN, M.D.		22d. ADDRESS 215 W. WASHINGTON ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/24/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY,	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH.CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR MAY 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

0000

RECEIVED

0000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07354

CERTIFICATE OF DEATH

07332

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-1	
c. LENGTH OF STAY IN TB 24 years		d. STREET ADDRESS 134 Broadway	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HERMAN ERNEST PECHART		4. DATE OF DEATH Month Day Year May 15, 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-1918
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) driver	
11. BIRTHPLACE (County & State, or foreign country) Boiling Springs, Pa		12. CITIZEN OF WHAT COUNTRY? Boiling Springs, Pa	
13. FATHER'S NAME Edward T. Pechart		14. MOTHER'S MAIDEN NAME Laura Fahrenstock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 183-12-1990	
17. INFORMANT Mrs. Betty Pechart, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor - brain stem - type 237X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) not determined (c) not determined		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-31 , 1967 to 5/15 , 1967 , that (I) (we) last saw the deceased alive on 5/15 , 1967 , and that death occurred at 10:45 P.M., from causes and on the date stated above.			
22a. SIGNATURE George Jennings		22b. DATE SIGNED 5/17/67	
22c. PHYSICIAN'S NAME (Type) George Jennings		22d. ADDRESS 318 N. Pot. St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-18-67	23c. NAME OF CEMETERY OR CREMATORY Springville, Cemetery	23d. LOCATION (City or Town) (County) (State) Boiling Springs, Pa.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAY 19 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

255

07355

CERTIFICATE OF DEATH

07331

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY Maryland Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN IB 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS Fahrney Keedy Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Harriett Grosh Remsberg			4. DATE OF DEATH Month Day Year May 15, 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1882	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Ruben Grosh		
14. MOTHER'S MAIDEN NAME Amelia Lovering			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Mrs Gladys Hoffman		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prodromal ulcer & hemorrhage</i> 5410 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic heart disease & atrial fibrillation</i>			INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>5/15, 1967</i> , to <i>5/15, 1967</i> , that (I) (we) last saw the deceased alive on <i>5/15, 1967</i> , and that death occurred at <i>10 P.M.</i> from causes and on the date stated above.					
22a. SIGNATURE <i>John H. Hornbaker</i>			22b. DATE SIGNED 5-16-67		22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.
22d. ADDRESS 154 West Washington St., Hagerstown, Md. 21740			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
23b. DATE THEREOF 5/18/67		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City or Town) (County) (State) Middletown Maryland	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc. Hagerstown, Maryland.			25a. REG'D BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

07355



TO : DIRECTOR, FBI (100-441100)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph memorandum or letter.]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

1
2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #3 Film #G388 5/15/67 pc

07356

CERTIFICATE OF DEATH

07333

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK		c. LENGTH OF STAY IN 1b 80.YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME		d. STREET ADDRESS W.MAIN ST.	
3. NAME OF DECEASED (Type or print) First Cora Middle Mabel Last Richards		4. DATE OF DEATH Month 5 Day 6 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL	11. BIRTHPLACE (County & State, or foreign country) FULTON COUNTY PENNA.
13. FATHER'S NAME JOHN BROOKE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212.14.7860	
17. INFORMANT MRS H. EDWIN BLAIR		Address: HAGERSTOWN MD. 673 OAK HILL AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sen Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4/24/67</i> , 19 to <i>5/6/67</i> , 19, that (I) (we) last saw the deceased alive on <i>5/6/67</i> , 19, and that death occurred at <i>12:25 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>FB Thomas III M.D.</i>		22b. DATE SIGNED <i>5/8/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>FB Thomas III M.D.</i>		22d. ADDRESS <i>Hancock, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF <i>5.9.67</i>	23c. NAME OF CEMETERY OR PRESBYTERIAN	23d. LOCATION (City or Town) (County) (State) HANCOCK WASHINGTON MD.
24. FUNERAL DIRECTOR <i>Howard F. Hone Hancock Md</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 11 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01333

03350

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

4-1000

80.00

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

100

100

100

100

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

WATKINS, JOHN

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07357

CERTIFICATE OF DEATH

07334

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>5 weeks</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cavetown</u> <u>211</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter Earl Shank</u>				4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 8, 1890</u>	
				9. AGE (In years last birthday) yrs. <u>76</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Core Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Foundry</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lappans Cross Rds. Md.</u>	
13. FATHER'S NAME <u>Joseph Shank</u>				14. MOTHER'S MAIDEN NAME <u>Wash. Co. Susan Lapole</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-09-2441</u>		17. INFORMANT <u>Mrs. Walter E. Shank</u> Address <u>Cavetown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Carcinoma</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-10</u> , 19 <u>60</u> , to <u>5-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-25</u> 19 <u>65</u> , and that death occurred at <u>11:30</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. Hess</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>				22d. ADDRESS <u>Smithsburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Smithsburg, Washington, Md.</u>	
24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07358

CERTIFICATE OF DEATH

07335

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jackson Conv. Home</u>		d. STREET ADDRESS <u>206 No Colonial Drive</u>	
3. NAME OF DECEASED (Type or print) <u>MAUDE</u> First <u>PAKMER</u> Middle <u>SHANNON</u> Last		4. DATE OF DEATH <u>May 28 1967</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3 1868</u>
9. AGE (In years last birthday) <u>99</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Va. Parkersburg Wood Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George A. Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Lucille Etchison</u>		Address <u>206 N. Colonial Dr</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO (b) <u>Arteriosclerotic heart disease with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>vascular hypertension, arteriosclerotic</u> (c) <u>Indefinite</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20 19 67</u> , to <u>May 28 19 67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 20 19 67</u> , and that death occurred at <u>2:15 A.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Kneisley</u>		22b. DATE SIGNED <u>5/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/30/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederick Frederick Co Md</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05328

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07359

CERTIFICATE OF DEATH

07336

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg c. LENGTH OF STAY IN 1b 15 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 113 S Mechanic Street		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg d. STREET ADDRESS 113 S. Mechanic Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SILAS Middle DAVIS Last SHIPLEY		4. DATE OF DEATH Month May Day 25 Year 19 67	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb.. 6 1887	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 3 Days 18 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Supt. Maintenance		10b. KIND OF BUSINESS OR INDUSTRY College	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Fonrose Shipley		14. MOTHER'S MAIDEN NAME Catherine Griffith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 18 0250	
17. INFORMANT Mildred Mc Graw		Address 113 S. Mechanic St. Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY FIBROSIS AND EMPHYSEMA INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/17 , 19 66 , to 5/2 , 19 67 , that (I) (we) last saw the deceased alive on 5/2/67 19 67 , and that death occurred at 4 A.M. 5/2/67 Vol. the causes and on the date stated above.			
22a. SIGNATURE R. Amarillo		22b. DATE SIGNED 5/26/67	
22c. PHYSICIAN'S NAME (Type) R. Amarillo		22d. ADDRESS Sharpsburg, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 27-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town or county) (State) Sharpsburg Maryland	
24. FUNERAL DIRECTOR Albert L.. Leaf Williams		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS sport Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE MAY 29 1967			

07552

CERTIFICATE OF DEATH

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of registrar
9. Signature of medical officer
10. Signature of informant

THE REGISTERING OFFICE

PALESTINE

2/10/52

1. Name of deceased

MAY 1952

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07360

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07337

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>35 Years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2416 Virginia Ave</u>				d. STREET ADDRESS <u>2416 Virginia Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLIFFORD HULLEN SHOOP</u>				4. DATE OF DEATH Month Day Year <u>May 25 1967</u> 19			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16 1886</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brpom Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Mt Aetna Wash Co Md..</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Levi Shoop</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Foltz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-40-3410</u>		17. INFORMANT <u>Dallas E Shoop</u> Address <u>2416 Virginia Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>hypertensive arteriosclerotic C.V.D.</u> DUE TO (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Naturol causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H.N. Weeks</u>		EXAMINER'S NAME (Type) <u>H.N. Weeks, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5/26/67 22. DATE SIGNED <u>580 Northern Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md..</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>				ADDRESS <u>Funeral Home Inc</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 01-10-2001 BY 60322 UCBAW/DAW

18577

FROM: [illegible] TO: [illegible]

00530

18577



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07361

CERTIFICATE OF DEATH

07338

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 1401 Virginia Ave.	
3. NAME OF DECEASED (Type or print) First EDGAR Middle GABE Last SMITH		4. DATE OF DEATH Month May Day 1 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1895
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) traffic mgr.		10b. KIND OF BUSINESS OR INDUSTRY snad blast. Mfg	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Smith		14. MOTHER'S MAIDEN NAME Florence Gabe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. 711-07-1868A	
17. INFORMANT Katharine Smith		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 18 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 30, 1967 to May 1, 1967 , that (I) (we) last saw the deceased alive on April 19, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE <i>Edmond H. Hagg</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-67	
23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Maryland	
24. FUNERAL DIRECTOR Minnich Funeral Home		25. REC'D BY REGISTRAR MAY 5 1967	
ADDRESS Hagerstown, Md		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

23501

CERTIFICATE OF DEATH

0.000

Washington Maryland

Washington

1901

DEATH

1901

1901

1901

1901

1901

1901

1901

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07339

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SMITHSBURG RT.#2 21-1	
c. LENGTH OF STAY IN b 1 HR.		d. STREET ADDRESS CAVE HILL RD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle CALVIN Last SMITH JR.		4. DATE OF DEATH Month MAY Day 1 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/1967
9. AGE (In years last birthday) 11 weeks		10. IF UNDER 1 YEAR Months 2 Days 1 Hours 21 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY INFANT	
11. BIRTHPLACE (State or foreign country) HAGERSTOWN MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RALPH CALVIN SMITH SR.		14. MOTHER'S MAIDEN NAME MARY ANN WOLFINGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. RALPH CALVIN SMITH SR.		Address SMITHSBURG RT.#2 MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute interstitial pneumonia 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SDH DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) EDWARD W. DITTO III		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
217 W. WASHINGTON ST. HAG., MD.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED 5-2-67	
23a. BURIAL CREMATION, REMOVAL, OR OTHER BURIAL		23b. DATE THEREOF 5/2/67	
23c. NAME OF CEMETERY OR CREMATORY MANOR CHURCH CEM.		23d. LOCATION (City or town) (County) (State) WASHINGTON CO. MD.	
24. FUNERAL DIRECTOR W. J. Norman, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAY 4 1967	
ADDRESS 7-227108		25b. REGISTRAR'S SIGNATURE Charles Judge	

2785

01010

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

1000

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

EDWARD W. BILTO III
111 W. WASHINGTON ST. HAS. MD.

EDWARD W. BILTO III

EDWARD W. BILTO III

EDWARD W. BILTO III

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the page. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07363

CERTIFICATE OF DEATH

07340

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b LIFE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 236 NORTH MULBERRY				d. STREET ADDRESS 236 NORTH MULBERRY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET KATHLEEN SPESSARD				4. DATE OF DEATH Month Day Year MAY 4, 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG. 19, 1902		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F. SEMLER				14. MOTHER'S MAIDEN NAME IDA J. LIZER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. *****		17. INFORMANT RUSSELL L. SPESSARD, 232 N. MULBERRY, HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH minutes hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) none					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) - - -	
21. I certify that (I) (the hospital) attended the deceased from Jan 24 , 19 66 , to May 4 , 19 67 that (I) (we) saw the deceased alive on May 1 , 19 67 , and that death occurred at 8:30 P M, from causes and on the date stated above.							
22a. SIGNATURE Harold R. Tritch				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED MAY 6, 1967	
22c. PHYSICIAN'S NAME (Type) DR. H. R. TRITCH, JR. M.D.				22d. ADDRESS 302 NORTH POTOMAC ST. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND..				25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

100-1000

STATE OF NEW YORK

100-1000

[The remainder of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07341

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Chewsville				c. LENGTH OF STAY IN TB 4 Years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beck Road				d. STREET ADDRESS Beck Road			
3. NAME OF DECEASED (Type or print) HARRY GORDON SPRECHER				4. DATE OF DEATH Month May Day 25 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19 1923	
9. AGE (In years lost birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar F. Sprecher				14. MOTHER'S MAIDEN NAME Bessie Longanecker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W.#2		16. SOCIAL SECURITY NO. 220-16-1916		17. INFORMANT Lester E. Sprecher Address 1760 Sheridan Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 982X IMMEDIATE CAUSE (a) 1) Hemorrhage from severed right femoral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) 2) Stab wound in left lower quadrant (c) sudden				INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Wife xxxxx				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Wife stabbed victim with hunting knife					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:20 p.m. 5/25 1967		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Trailer		20f. (City or town) (County) (State) Near Chewsville Wash. Co. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Howard N. Weeks		EXAMINER'S NAME (Type) Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) Hagerstown, Md.		5/26/67 22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

07300

1451

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07365

CERTIFICATE OF DEATH

07342

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 45 years		d. STREET ADDRESS 56 E. Franklin St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle LESTER Last STINEBAUGH		4. DATE OF DEATH Month May Day 24 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) assembler		11b. KIND OF BUSINESS OR INDUSTRY sand blast	
11. BIRTHPLACE (County & State, or foreign country) Chambersburg, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John J. Stinebaugh		14. MOTHER'S MAIDEN NAME Agnes L. Leakway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Galdys Stinebaugh, Hag., Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia 1919 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell carcinoma, pharynx with DUE TO (c) esophageal and tracheal obstruction		INTERVAL BETWEEN ONSET AND DEATH 12 hours 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on May 24 19 67 , and that death occurred at 12:40 PM from causes and on the date stated above.			
22a. SIGNATURE John H. Kehne M.D.		22b. DATE SIGNED 5-25-67	
22c. PHYSICIAN'S NAME (Type) John H. Kehne, M.D.		22d. ADDRESS 1829 Ravenwood Hgts., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-27-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

073862

073862

12 hours

2 weeks

known all evidence, please with
evidence and training observation

12:00 PM

12:00 PM

John E. Smith, Jr., Hagerstown, Md.

John E. Smith, Jr., Hagerstown, Md.

John E. Smith, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07366
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg c. LENGTH OF STAY IN 1d Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 107 S. Mechanic St.		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg d. STREET ADDRESS 107 S. Mechanic St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Margaret Last Stockslager		4. DATE OF DEATH Month May Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27 1897
9. AGE (In years last birthday) 69 yrs.		10. UNDER 1 YEAR Months 11 Days 4	10. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Sharpsburg Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Clarence Mongan		14. MOTHER'S MAIDEN NAME Lillie Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-16-2085	
17. INFORMANT Mr. James Stockslager		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/19 , 19 66 , to 5/3 , 19 67 , that (I) (we) last saw the deceased alive on 5/3 , 19 67 , and that death occurred at 6P.M. from the causes and on the date stated above.			
22a. SIGNATURE R. Amarillo		22b. DATE SIGNED 5/3/67	
22c. PHYSICIAN'S NAME (Type) R. Amarillo		22d. ADDRESS Sharpsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 6-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town or county) (State) Sharpsburg Maryland	
24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport Md.	
25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

MEDICAL CERTIFICATION

03366



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
07367					CERTIFICATE OF DEATH					07344				
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>					c. LENGTH OF STAY IN 1b <u>—</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75.3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Clearview Nursing Home</u>					d. STREET ADDRESS <u>257 S. Wash. St.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>GRACE</u> Last <u>STRITE</u>					4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1967</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/13/1873</u>		9. AGE (In years lost birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Amos Deatrach</u>					14. MOTHER'S MAIDEN NAME <u>Amelia Weaver</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Jacob L. Deatrach - Waynesboro, Pa.</u> Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular</u> <u>4221</u> DUE TO <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>—</u> DUE TO <u>—</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1939</u> to <u>5/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/1</u> , 19 <u>67</u> , and that death occurred at <u>1:30 P.M.</u> , from causes and on the date stated above.														
22a. SIGNATURE <u>W.C. Brewer, M.D.</u>										22b. DATE SIGNED <u>5/3/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>W.C. Brewer, M.D.</u>										22d. ADDRESS <u>Greencastle, Pa.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
<u>Burial</u>			<u>5/6/67</u>		<u>Cedar Hill</u>			<u>Greencastle, Pa.</u>						
24. FUNERAL DIRECTOR <u>A.E. Minnich - Greencastle, Pa.</u>					25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Jager</u>							

5130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07368

07345

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Penna. b. COUNTY Franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 14 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor		d. STREET ADDRESS 135 Snider Ave.	
3. NAME OF DECEASED (Type or print) First Harris Middle Newton Last Summer		4. DATE OF DEATH Month May Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1887
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Major		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME B. R. Summer		14. MOTHER'S MAIDEN NAME May Duey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 252-58-0875A	
17. INFORMANT Mrs. Rosalie S. Dayhoff		Address Waynesboro, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular Arteriosclerosis DUE TO (c) 4 yrs		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 22 , 19 66 , to May 9 , 19 67 , that (I) (we) last saw the deceased alive on May 9 , 19 67 , and that death occurred at 9:20 M, from causes and on the date stated above.			
22a. SIGNATURE Charles A. Hoffman M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22b. DATE SIGNED 5/12/67	
22d. ADDRESS 214 N. Pot-st. Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/1967	
23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City & town) (County) (State) Waynesboro, Franklin, Penna.	
24. FUNERAL DIRECTOR Walter J. Love		ADDRESS Waynesboro, Penna.	
25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1998

103

12

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07363

CERTIFICATE OF DEATH

07346

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> c. LENGTH OF STAY IN 1b <u>60yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> d. STREET ADDRESS <u>7 Braxton Av.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen Cleo Summers</u>		4. DATE OF DEATH Month Day Year <u>May 28 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 13 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>28 19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sharpsburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George H. King</u>		14. MOTHER'S MAIDEN NAME <u>Mary V. Callaman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Malcoma Brown</u>		Address <u>243 N. Jonathan St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio-Sclerosis</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 20/67</u> to <u>May 28/67</u> , that (I) (we) last saw the deceased alive on <u>May 28/67</u> and that death occurred at <u>9:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Beachley</u>		22b. DATE SIGNED <u>May 30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. Beachley</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 1 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR <u>John R. Watson Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 2 1967</u>	

07302

REPORT OF REVENUE

12

[Faint, illegible handwritten text, possibly a signature or date, spanning the bottom half of the page.]

07370

07347

VR A15 (4)
25M 1/67

THE OFFICE OF THE ADJUTANT GENERAL

10330

TO THE DIRECTOR OF THE BUREAU OF THE ARMY
FROM THE ADJUTANT GENERAL
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07348

07371

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Rfd. 1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Jason Lester Thomas				4. DATE OF DEATH Month Day Year May 25, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1890	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days 1 22		11. IF UNDER 24 HRS. Hours Min. 1 22			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Rural Boonsboro, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Luther Thomas				14. MOTHER'S MAIDEN NAME Ellen Long			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 215-36-7096		17. INFORMANT Address Mrs. Nannie B. Thomas, Rfd. 1 Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension & cardio vascular disease 443X DUE TO (b) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 1 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 25, 1967 , to May 25, 1967 , that (I) (we) last saw the deceased alive on May 25, 1967 , and that death occurred at L.P. M, from causes and on the date stated above.							
22a. SIGNATURE <i>G. W. LeVan</i>				22b. DATE SIGNED May 26, 1967			
22c. PHYSICIAN'S NAME (Type) G. W. LeVan				22d. ADDRESS Boonsboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-29-67		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR John H. Best, Jr. 112 N. Main St. Boonsboro, Md.				25a. MARYLAND REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2000

356

1.

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07349

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland c. LENGTH OF STAY IN 1b 6 Weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 115 Clarkson Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore, Md d. STREET ADDRESS 924 Watson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Simon Middle (NMN) Last Walker		4. DATE OF DEATH Month May Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 1 1893
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Cedar Hill, Va.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Jack Walker	
14. MOTHER'S MAIDEN NAME Matilda Myers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes World War 1	
16. SOCIAL SECURITY NO. 217-07-5980		17. INFORMANT Mrs. Maude Myers 115 Clarkson Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) general arteriosclerosis DUE TO (b) arteriosclerotic heart disease and DUE TO (c) cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X		INTERVAL BETWEEN ONSET AND DEATH 25 yr 10 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Suspected adenocarcinoma prostate & metastases		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 e.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23 1967	
22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR John R. Watson of Hagerstown Md.		24a. REC'D BY REGISTRAR MAY 23 1967	
24b. REGISTRAR'S SIGNATURE Charles Judge		DATE SIGNED 5-19-67	

305

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07373 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07350

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 421 D, Sumans Ave		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE New Jersey b. COUNTY Essex County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark, N. J. d. STREET ADDRESS 711 South 11th. Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl (NMN) Ware		4. DATE OF DEATH Month May Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18 1916 9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gilbert Ware		14. MOTHER'S MAIDEN NAME Carrie Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes World War 2		16. SOCIAL SECURITY NO. 230-09-3627	
17. INFORMANT Jennie B. Ware Newark N. J.		Address 711 South 11th St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) generalized arteriosclerosis DUE TO (c) Arteriosclerotic Heart Disease 20 yrs		INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.		22. DATE SIGNED 5-13-67	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 217 W. Wash. St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-16-1967	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR John R. Watson Jr. Hagerstown Md		25a. REC'D BY REGISTRAR MAY 16 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

6880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07374		07351	
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
c. LENGTH OF STAY IN 1b 50 YRS.		d. STREET ADDRESS 36 N. WALNUT ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 36 N. WALNUT ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUY Middle BOYD Last WETZEL		4. DATE OF DEATH Month MAY Day 10 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/1913
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10b. KIND OF BUSINESS OR INDUSTRY SHEET METAL MFG. CO. VIRGINIA	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY W. WETZEL		14. MOTHER'S MAIDEN NAME AUDREY ACORD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES W.W.#2		16. SOCIAL SECURITY NO. 217-09-9666	
17. INFORMANT MR. CLYDE H. WETZEL		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Anterior Myocardial Infarction (b) DUE TO Anterior Myocardial Infarction (c) DUE TO Anterior Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Polycystic Degeneration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-23, 1967, to April 27, 1967, that (I) (we) last saw the deceased alive on April 27, 1967, and that death occurred at 6:00 p.m. from causes and on the date stated above.		22a. SIGNATURE E. R. Haddigshon	
22b. PHYSICIAN'S NAME (Type) E. R. Haddigshon		22c. ADDRESS 300 N. KORMENT, HAGERSTOWN, MD.	
23a. BURIAL CREMATION REMOVED <input checked="" type="checkbox"/> BURIAL		23b. DATE THEREOF 5/13/67	
23c. NAME OF CEMETERY OR CREMATORY GREEN LAWN CEM.		23d. LOCATION (City or town) (County) (State) WILLIAMSPORT WASH. MD.	
24. FUNERAL DIRECTOR W. J. Korment, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

000000

OFFICE OF THE

1974

CHIEF OF BUREAU

ADMINISTRATIVE

TO

FROM

DATE

RE

BY

FOR

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

1974

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07375

CERTIFICATE OF DEATH

07352

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> c. LENGTH OF STAY IN 1b <u>65yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> d. STREET ADDRESS <u>410 Park Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Henry Wilkerson</u> First Middle Last			4. DATE OF DEATH <u>May 30</u> 19 <u>67</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 8 1894</u>	9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Burkittsville, Md.</u>			
13. FATHER'S NAME <u>Robert Wilkerson</u>			14. MOTHER'S MAIDEN NAME <u>Lucy Henderson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-14-1370</u>		17. INFORMANT Address <u>Mrs. Josephine Wilkerson, 410 Park Pl.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Lymphogenous Leucemia</u> <u>2040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>14 mo.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>66</u> , to <u>May 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 30</u> 19 <u>67</u> , and that death occurred at <u>12 P</u> M, from causes on and on the date stated above.							
22a. SIGNATURE <u>Robert P. Conrad</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6-1-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>			22d. ADDRESS <u>137 W. Washington Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 3 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Maryland</u>				
24. FUNERAL DIRECTOR ADDRESS <u>John R Watson Jr. Hagerstown Md.</u>			25a. REC'D BY REGISTRAR DATE <u>JUN 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

03325

CHARTER OF DATA

CHARTER OF DATA

CHARTER OF DATA

DE

CHARTER OF DATA

CHARTER OF DATA

CHARTER OF DATA

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07376

CERTIFICATE OF DEATH

07353

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>118 N. Mont Ualla Ave.</u>		d. STREET ADDRESS <u>329 Elizabeth Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Gussie</u> Middle <u>Virginia</u> Last <u>Willis</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe Organ Mfg.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Leetown, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bush Rod Willis</u>		14. MOTHER'S MAIDEN NAME <u>Anna Belle Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-7913</u>	
17. INFORMANT <u>Mrs. Mae E. Rockwell</u>		Address <u>Hagerstown, Md.</u> <u>118 N. Mont Ualla Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic Cardiac Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>2-3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic heart disease; Cardiac failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>13 March, 1965</u> to <u>17 May, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 1965</u> , and that death occurred at <u>1 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard T. Binford</u>		22b. DATE SIGNED <u>19 May 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard T. Binford, M. D.</u>		22d. ADDRESS <u>1135 Potomac Avenue Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> <u>Rest Haven Funeral Chapel</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAY 19 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376

1376